

Communicable Disease Reporting Rule for Physicians, Hospitals, and Laboratories

410 IAC 1-2.3

Effective October 11, 2000

**The Indiana State Dept of Health serves to *promote*,
protect and *provide* for the public health of people in
Indiana**



**Indiana State
Department of Health**

Introduction

The Communicable Disease Reporting Rule for Physicians, Hospitals, and Laboratories is promulgated under Indiana Code 16-41-2-1, which allows the Indiana State Department of Health (ISDH) to establish reporting, monitoring, and preventive procedures for communicable diseases. The Rule provides reporting instructions for physicians, hospital administrators (or their designee), and laboratories for diseases or laboratory evidence that a disease might exist. It also incorporates by reference various documents that provide case definitions, as well as guidance on measures to prevent further spread of the diseases. Diseases covered by the Rule must meet one or more of the following six criteria: 1) a nationally reportable disease, 2) a vaccine-preventable disease, 3) an emerging infectious disease, 4) a significant organism with emerging drug resistance, 5) a disease with high bioterrorism potential, and/or 6) a disease that requires a public health response.

The Rule can be divided into three basic components.

1. Definitions - to ensure that all who use the Rule will understand the terms used.
2. Reporting Requirements - includes the actual requirements for reporting, the list of reportable diseases, as well as statements concerning the confidentiality of the information provided in disease reports. Indiana law is explicit in protecting the confidentiality of an individual's medical or epidemiological data.
3. Public Health Intervention Information for all of the reportable diseases.

While developing the definition and intervention components of the Rule, the ISDH staff used a number of publications from the Centers for Disease Control and Prevention; recommendations from the American Academy of Pediatrics, Committee on Infectious Diseases; recommendations from the Association of Practitioners in Infection Control; American Public Health Association's Control of Communicable Diseases Manual; and recommendations from the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

We wish to extend a special thank you to the physicians and public health nurses from Indiana's local health departments, infection control practitioners, and others who reviewed the Rule and provided valuable comments.

We know that changes in medical science and emerging diseases will require future review and revision of the Communicable Disease Reporting Rule. The ISDH Communicable Disease staff welcomes your comments, criticisms, and recommendations for future revisions. Please send them to:

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Definitions

Sec. 1. The definitions in this rule apply throughout this rule.

Sec. 2. “Active surveillance” means taking measures to identify all cases of an infectious disease by the local health officer or department, including, but not limited to, calling or otherwise contacting:

- (1) physicians;
- (2) hospitals;
- (3) clinics;
- (4) laboratories; and
- (5) others who might be aware of cases of disease.

Sec. 3. “Airborne precautions” means transmission-based precautions for health care facilities designed to reduce the risk of airborne transmission of infectious agents. Requirements for airborne precautions are presented in Guidelines for Isolation Precautions in Hospitals, Infection Control and Hospital Epidemiology, Volume 17, No. 1, January 1996

Sec. 4. “Bloodborne pathogens” means pathogenic micro-organisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, the following:

- (1) HBV.
- (2) HCV.
- (3) HIV.

Sec. 5. “Carrier” means a person who harbors a specific infectious agent without discernible clinical disease and serves as a potential source of infection.

Sec. 6. “Case” means a person who harbors a communicable disease, usually in the presence of discernible clinical disease, symptoms, or signs and may serve as a potential source of infection. Specific case definitions are defined in the Centers for Disease Control and Prevention publication Case Conditions Under Public Health Surveillance, MMWR, Recommendations and Reports, May 2, 1997, Volume 46, No. RR-10 and by reference are incorporated into this rule.

Sec. 7. “Case ascertainment” means collecting clinical, laboratory, and epidemiological information for the purpose of determining whether a reported case of disease met the standard clinical or laboratory case definition for the disease or both

Sec. 8. “Case management” means systematic monitoring and quality assurance of diagnosis, treatment, control, and prevention strategies performed by public health employees, including, but not limited to, local health officers and their designees.

Sec. 9. “Cleaning” means the removal by scrubbing and washing, as with water and soap or suitable detergent, or by vacuum cleaning of infectious agents and of organic matter from surfaces on which and in which infectious agents may find favorable conditions for surviving or multiplying.

Sec. 10. “Commissioner” means the state health commissioner or authorized officers, employees, or agents of the department.

Sec. 11. “Communicable disease” means an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment.

Sec. 12. “Concurrent disinfection” means the application of disinfective measures including use of an EPA approved disinfectant cleaning agent as soon as possible after the discharge of infectious material from the body of an infected person or after the soiling of articles with such infectious discharges.

Sec. 13. “Contact” means a person or animal that has been in association with an infected person or animal, or a contaminated environment that is likely to provide an opportunity to acquire the infection.

Sec. 14. “Contact precautions” means procedures in addition to standard precautions to prevent transmission in health care facilities of diseases or conditions which are spread primarily by direct or indirect contact. Direct contact transmission involves skin-to-skin contact and physical transfer of micro-organisms to a susceptible host from an infected or colonized person. For details of the precautions see Guideline for Isolation Precautions in Hospitals, Infection Control and Hospital Epidemiology, Volume 17, No. 1, January 1996.

Sec. 15. “Contact tracing” means the use of epidemiological methods to confidentially locate, counsel, and refer for medical evaluation and possible treatment of person or persons who have been in contact with someone with a communicable disease in a manner that might provide an opportunity to acquire the disease.

Sec. 16. (a) “Contaminated sharp” means an object that meets the following conditions:

- (1) Is capable of cutting or penetrating the skin.
- (2) Has been in contact with blood or other potentially infectious materials.
- (b) The term includes, but is not limited to, the following:
 - (1) Hypodermic or suture needle.
 - (2) Scalpel blade.
 - (3) Pipette.
 - (4) Lancet.
 - (5) Broken glass.

Sec. 17. “Contamination” means the presence of an infectious agent:

- (1) on a body surface;
- (2) in clothes;
- (3) in bedding;
- (4) on toys;

- (5) on surgical instruments or dressings; or
- (6) in or on other inanimate articles or substances, including water and food.

Sec. 18. “Control measures” means those measures to reduce the threat of disease transmission from a case of communicable disease.

Sec. 19. “Counseling and testing site” means a place that has been designated, approved, and registered with the department to counsel and test individuals anonymously or confidentially, or both, for HIV.

Sec. 20. “Day care center” means a day nursery that is any institution operated for the purpose of providing care and maintenance to children separated from their parent, guardian, or custodian during a part of the day for two (2) or more consecutive weeks, except a school or other bona fide educational institution.

Sec. 21. “Decontamination” means the use of physical or chemical means to remove, inactivate, or destroy bloodborne and other pathogens on a surface or item that does not require sterilization, thus rendering the item safe for handling, use, or disposal.

Sec. 22. “Department” means the Indiana state department of health.

Sec. 23. “Droplet precautions” means measures to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 micrometers in size) containing micro-organisms generated from a person who has a clinical disease or who is a carrier of the micro-organism. For complete description, see Guideline for Isolation Precautions in Hospitals, Infection Control and Hospital Epidemiology, Volume 17, No. 1, 1996.

Sec. 24. “Food handler” means an individual who works with unpackaged food, food equipment or utensils, or food contact surfaces.

Sec. 25. “Hand washing procedures” means vigorous washing of hands using soap and running water from an approved water supply, followed by drying hands using clean paper or single use cloth toweling or air drying devices. An alcohol-based hand rinse/foam may be used when hands are not visibly soiled and in accordance with manufacturer’s guidelines.

Sec. 26. “HBV” means hepatitis B virus.

Sec. 27. “HCV” means hepatitis C virus.

Sec. 28. “Health care facility” includes the following:

- (1) Hospitals licensed under IC 16-21-2, private mental health institutions licensed under IC 12-25, and tuberculosis hospitals established under IC 16-24-1.

- (2) Health facilities licensed under IC 16-28.
- (3) Rehabilitation facilities and kidney disease treatment centers.

Sec. 29. “Health care worker” means a person who provides services whether as an individual health care provider, volunteer, or student at or employee of a health care facility.

Sec. 30. “HIV” means human immunodeficiency virus.

Sec. 31. “HIV infection/disease” means a condition that meets the criteria of one (1) of the following:

- (1) Persons who meet the Centers for Disease Control and Prevention (CDC) definition of AIDS, as found in Morbidity and Mortality Weekly Report, Volume 41, Recommendations and Reports No. RR-17, December 18, 1992.
- (2) Persons who have serologic evidence of HIV infection.
- (3) Other persons with signs or symptoms, or both, that cause the attending physician to strongly suspect HIV infection.
- (4) Infants born to mothers with HIV infection/disease and who have not been determined to be a seroreverter as defined in the Morbidity and Mortality Weekly Report Volume 43, No. RR-12, 1994 Revised Classified System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age.
- (5) Children under thirteen (13) years of age who meet the CDC definition of HIV infection or AIDS or both, as found in Morbidity and Mortality Weekly Report Volume 43, No. RR-12, 1994 Revised Classified System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age.
- (6) Persons who meet the CDC Revised Surveillance Case Definition for HIV Infection, as found in Morbidity and Mortality Weekly Report, Vol. 48, No. RR-13, 1999, CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome.

Sec. 32. “Intervention or prevention activities” means:

- (1) the promotion of health by personal or community-wide efforts;
- (2) early detection to correct deviations from good health; and
- (3) the reduction of impairments and disabilities caused by existing departures from good health.

Sec. 33. “Invasive disease” means disease:

- (1) in association with positive bacterial cultures from:
 - (A) blood;
 - (B) cerebrospinal fluid;
 - (C) pleural fluid;
 - (D) pericardial fluid;
 - (E) synovial fluid; or
 - (F) other usually sterile body fluid; or

(2) such as epiglottitis or necrotizing fasciitis, in association with positive bacterial cultures from those sites.

Sec. 34. “Local health officer” means the county/city health officer or authorized officers, employees, or agents of the county/city health department.

Sec. 35. “Medical laboratory” means an entity that engages in the biological, microbiological, serological, chemical, immuno-hematological, radioimmunological, hematological, cytological, pathological, or other examination of materials derived from the human body for the detection, diagnosis, prevention, or treatment of any disease, infection, or impairment, or the assessment of human health.

Sec. 36. “Other potentially infectious materials” means:

- (1) semen;
- (2) vaginal secretions;
- (3) cerebrospinal fluid;
- (4) synovial fluid;
- (5) pleural fluid;
- (6) pericardial fluid;
- (7) peritoneal fluid;
- (8) amniotic fluid;
- (9) saliva in dental procedures;
- (10) any body fluid that is visibly contaminated with blood;
- (11) all body fluids where it is difficult or impossible to differentiate between body fluids;
- (12) any unfixed tissue or organ (other than intact skin) from a human, living or dead;
- (13) any HIV-containing cell or tissue cultures, organ cultures and HIV-containing or HBV-containing culture medium; or
- (14) blood, organs, or other tissues from experimental animals infected with HIV, HBV, or HCV.

Sec. 37. “Outbreak” means cases of disease occurring in a community, region, or particular population at a rate clearly in excess of that which is normally expected.

Sec. 38. “Quarantine” means the restriction of the activities or confinement of well persons or animals who have, or may have been exposed to a case of communicable disease during its period of communicability to prevent disease transmission during the incubation period, if infection should occur.

Sec. 39. “Restriction of activities” means limitations placed on the activities of persons with disease or infection to prevent transmission of communicable diseases to other individuals.

Sec. 40. “Serious and present danger to health”, as used in IC 16-41-9-1 and this rule, means one (1) or more of the following:

- (1) Failure to comply with the measures specified under this rule.

- (2) Repeated behavior by a carrier or case that has been demonstrated epidemiologically to transmit, or evidences a careless disregard for the transmission of the disease to others.
- (3) A substantial likelihood that a carrier or case will repeatedly transmit the disease to others as is evidenced by that individual's past behavior, or by statements of the individual that are credible indicators of the individual's intention.
- (4) Affirmative misrepresentation by a carrier of his or her carrier status prior to engaging in any behavior that has been epidemiologically demonstrated to transmit the disease.
- (5) Failure or refusal to carry out the carrier's or case's duty to warn under IC 16-41-7-1.

Sec. 41. "Sexually transmitted disease" means local or systemic communicable diseases due to infectious agents, generally transmitted person-to-person by sexual intercourse on genital mucosal contact including, but not limited to, the following:

- (1) HIV.
- (2) HBV.
- (3) HCV.
- (4) Gonorrhea.
- (5) Chlamydia.
- (6) Syphilis.
- (7) Chancroid.
- (8) Granuloma inguinale.

Sec. 42. "Standard precautions" means measures used for all patients to prevent the nosocomial spread of micro-organisms in hospitals. Requirements of standard precautions are presented in Guideline for Isolation Precautions in Hospitals, Infection Control and Hospital Epidemiology, Volume 17, No. 1, January 1996.

Sec. 43. "Sterilize" means the use of physical or chemical procedures to destroy all microbial life, including highly resistant bacterial endospores.

Sec. 44. "Suspect case" means a person whose medical history, signs, and symptoms suggest that this person may be incubating or may be actively infected with some communicable disease

Sec. 45. "Terminal cleaning" means routine cleaning to remove dust, soil, and microbial contamination on inanimate surfaces and is done after a patient has been removed by death or transfer, or has ceased to be a source of infection, or after isolation or other practices/precautions have been discontinued.

Sec. 46. “Universal precautions” means an approach to infection control in which all human blood and certain body fluids are treated as if known to be infectious for HIV, HBV, HCV, and other bloodborne pathogens.

Reporting Requirements

Physician and Hospital Administrator Reporting

Sec. 47. (a) It shall be the duty of each physician licensed under IC 25-22.5, and each administrator of a hospital licensed under IC 16-21, or the administrator’s representative, to report all cases, and suspected cases of the diseases listed in subsection (d). Reporting of specimen results by a laboratory to health officials does not nullify the physician’s or administrator’s obligations to report said case.

(b) The report required by subsection (a) shall be made to the local health officer in whose jurisdiction the patient was examined at the time the diagnosis was made or suspected. If the patient is a resident of a different jurisdiction, the local health jurisdiction receiving the report shall forward the report to the local health jurisdiction where the patient resides. If a person who is required to report is unable to make a report to the local health officer within the time mandated by this rule, a report shall be made directly to the department within the time mandated by this rule.

(c) Any reports of diseases required by subsection (a) shall include the following:

(1) The patient’s:

- (A) full name;
- (B) street address;
- (C) city;
- (D) zip code;
- (E) county of residence;
- (F) telephone number;
- (G) age or date of birth;
- (H) sex; and
- (I) race and ethnicity, if available.

(2) Date of onset.

(3) Diagnosis.

(4) Definitive diagnostic test results (for example, culture, IgM, serology, or Western Blot).

(5) Name, address, and telephone number of the attending physician.

(6) Other epidemiologically necessary information requested by the local health officer or the commissioner.

(7) Persons who are tested anonymously at a counseling and testing site cannot be reported using personal identifiers; rather, they are to be reported using a numeric identifier code. Age, race, sex, risk factors, and county of residence shall also be reported.

(8) Name, address, and telephone number of person completing report.

(d) The dangerous communicable diseases and conditions described in this subsection shall be

reported within the time specified. Diseases or conditions that are to be reported immediately to the local health officer shall be reported by telephone or other instantaneous means of communication on first knowledge or suspicion of the diagnosis. Diseases that are to be reported within seventy-two (72) hours shall be reported to the local health officer within seventy-two (72) hours of first knowledge or suspicion of the diagnosis by telephone, electronic data transfer, other confidential means of communication, or official report forms furnished by the department. During evening, weekend, and holiday hours, those required to report should report diseases required to be immediately reported to the after-hours duty officer at the local health department. If unable to contact the after-hours duty officer locally, or one has not been designated locally, those required to report shall file their reports with the after-hours duty officer at the department at (317) 233-1325 or (317) 233-8115.

DANGEROUS COMMUNICABLE DISEASES AND CONDITIONS		
Disease	When to Report (from probable diagnosis)	Disease Intervention Methods (section in this rule)
Acquired immuno- deficiency syndrome	See HIV Infection/Disease	Sec. 76
Animal bites	Within 24 hours	Sec. 52
Anthrax	Immediately	Sec. 53
Babesiosis	Within 72 hours	Sec. 54
Botulism	Immediately	Sec. 55
Brucellosis	Within 72 hours	Sec. 56
Campylobacteriosis	Within 72 hours	Sec. 57
Chancroid	Within 72 hours	Sec. 58
<i>Chlamydia trachomatis</i> , genital infection	Within 72 hours	Sec. 59
Cholera	Immediately	Sec. 60
Cryptosporidiosis	Within 72 hours	Sec. 61
<i>Cyclospora</i>	Within 72 hours	Sec. 62
Diphtheria	Immediately	Sec. 63
Ehrlichiosis	Within 72 hours	Sec. 64
Encephalitis, arboviral, Calif, EEE, WEE, SLE, West Nile	Immediately	Sec. 65
<i>Escherichia coli</i> , infection (including <i>E. coli</i> 0157:H7 and other entero-hemorrhagic types)	Immediately	Sec. 66
Gonorrhea	Within 72 hours	Sec. 67
Granuloma inguinale	Within 72 hours	Sec. 68

<i>Haemophilus influenzae</i> invasive disease	Immediately	Sec. 69
Hansen's disease (leprosy)	Within 72 hours	Sec. 70
Hantavirus pulmonary syndrome	Immediately	Sec. 71
Hemolytic uremic syndrome, postdiarrheal	Immediately	Sec. 66
Hepatitis, viral, Type A	Immediately	Sec. 72
Hepatitis, viral, Type B	Within 72 hours	Sec. 73
Hepatitis, viral, Type B, pregnant woman (acute and chronic), or perinatally exposed infant	Immediately (when discovered at or close to time of birth)	Sec. 73
Hepatitis, viral, Type C (acute)	Within 72 hours	Sec. 74
Hepatitis, viral, Type Delta	Within 72 hours	Sec. 73
Hepatitis, viral, unspecified	Within 72 hours	
Histoplasmosis	Within 72 hours	Sec. 75
HIV infection/disease	Within 72 hours	Sec. 76
HIV infection/disease, pregnant woman or perinatally exposed infant	Immediately (when discovered at or close to time of birth)	Sec. 76
Legionellosis	Within 72 hours	Sec. 77
Leptospirosis	Within 72 hours	Sec. 78
Listeriosis	Within 72 hours	Sec. 79
Lyme disease	Within 72 hours	Sec. 80
Lymphogranuloma venereum	Within 72 hours	Sec. 81
Malaria	Within 72 hours	Sec. 82
Measles (rubeola)	Immediately	Sec. 83
Meningitis, aseptic	Within 72 hours	Sec. 84
Meningococcal disease, invasive	Immediately	Sec. 85
Mumps	Within 72 hours	Sec. 86
Pertussis	Immediately	Sec. 88
Plague	Immediately	Sec. 89
Poliomyelitis	Immediately	Sec. 90
Psittacosis	Within 72 hours	Sec. 91
Q Fever	Immediately	Sec. 92
Rabies in humans or animals (confirmed and suspect animal with human exposure)	Immediately	Sec. 93

Rabies, postexposure treatment	Within 72 hours	Secs. 93 and 52
Rocky Mountain spotted fever	Within 72 hours	Sec. 94
Rubella (German measles)	Immediately	Sec. 95
Rubella congenital syndrome	Immediately	Sec. 95
Salmonellosis, other than typhoid fever	Within 72 hours	Sec. 96
Shigellosis	Immediately	Sec. 97
<i>Staphylococcus aureus</i> , Vancomycin resistance level of MIC \geq 8 μ g/mL	Immediately	Sec. 98
<i>Streptococcus pneumoniae</i> , invasive disease, and antimicrobial resistance pattern	Within 72 hours	Sec. 99
<i>Streptococcus</i> , Group A, invasive disease	Within 72 hours	Sec. 100
<i>Streptococcus</i> , Group B, invasive disease	Within 72 hours	Sec. 101
Syphilis	Within 72 hours	Sec. 102
Tetanus	Within 72 hours	Sec. 103
Toxic shock syndrome (<i>streptococcal</i> or <i>staphylococcal</i>)	Within 72 hours	Sec. 104
Trichinosis	Within 72 hours	Sec. 105
Tuberculosis, cases and suspects	Withing 72 hours	Sec. 106
Tularemia	Immediately	Sec. 107
Typhoid fever, cases and carriers	Immediately	Sec. 108
Typhus, endemic (flea borne)	Within 72 hours	Sec. 109
Varicella, resulting in hospitalization or death	Within 72 hours	Sec. 110
Yellow fever	Within 72 hours	Sec. 111
<i>Yersiniosis</i>	Within 72 hours	Sec. 112

DANGEROUS BUT NOT COMMUNICABLE DISEASES AND CONDITIONS OF PUBLIC HEALTH SIGNIFICANCE

Disease and Condition	When to Report (from probable diagnosis)	Disease Intervention Methods
Pediatric venous blood lead $\geq 10 \mu\text{g/dl}$ in children less than or equal to 6 years of age	Within 1 week	Sec. 87

(e) Reporting of HIV infection/disease shall include classification as defined in the CDC Morbidity and Mortality Weekly Report, Volume 41, No. RR-17, 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS among Adolescents and Adults. Reporting of HIV infection/disease in children less than thirteen (13) years of age shall include classification as defined in the CDC Morbidity and Mortality Weekly Report, Volume 43, No. RR-12, 1994 Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age. Supplemental reports shall be provided by the physician when an individual's classification changes. The CD4+ T-lymphocyte count and percentage, or viral load count, or both, shall be included with both initial and supplemental reports.

(f) The department, under the authority of IC 4-22-2-37.1, may adopt emergency rules to include mandatory reporting of emerging infectious diseases. Reports shall include the information specified in section 47(c) of this rule.

(g) Outbreaks of any of the following shall be reported immediately upon suspicion:

- (1) Any disease required to be reported under this section.
- (2) Diarrhea of the newborn (in hospitals or other institutions).
- (3) Foodborne or waterborne diseases in addition to those specified by name in this rule.
- (4) Streptococcal illnesses.
- (5) Conjunctivitis.
- (6) Impetigo.
- (7) Nosocomial disease within hospitals and health care facilities.
- (8) Influenza-like illness.
- (9) Unusual occurrence of disease.
- (10) Any disease (that is, anthrax, plague, tularemia, *Brucella* species, smallpox, or *botulinum* toxin) or chemical illness that is considered a bioterrorism threat, importation, or laboratory release.

(h) Failure to report constitutes a Class A infraction as specified by IC 16-41-2-8.

Laboratory Reporting Requirements

Sec. 48. (a) Each director, or the director's representative, of a medical laboratory in which examination of any specimen derived from the human body yields microscopic, bacteriologic,

immunologic, serologic, or other evidence of infection by any of the organisms or agents listed in section 48(d) of this rule shall report such findings and any other epidemiologically necessary information requested by the department. HIV serologic results of tests performed anonymously in conjunction with the operation of a counseling and testing site registered with the department shall not be identified by name of patient, but by a numeric identifier code; for appropriate method to report such results, see subsection (b).

(b) The report required by subsection (a) shall, at a minimum, include the following:

- (1) Name, date, results of test performed, the laboratory's normal limits for that test, and the laboratory's interpretation of the test results.
- (2) Name of person and date of birth or age from whom specimen was obtained.
- (3) Name, address, and telephone number of attending physician, hospital, clinic, or other specimen submitter.
- (4) Name, address, and telephone number of the laboratory performing the test.

(c) This subsection does not preclude laboratories from testing specimens, which, when submitted to the laboratory, are identified by a numeric identifier code and not by name of patient. If testing of such a specimen, identified by numeric code, produces results that are required to be reported under this rule, the laboratory shall submit a report that includes the following:

- (1) Numeric identifier code, date, and results of tests performed.
- (2) Name and address of attending physician, hospital, clinic, or other.
- (3) Name and address of the laboratory performing the test.

(d) Laboratory findings demonstrating evidence of the following infections, diseases, or conditions shall be reported at least weekly to the department:

(1) Arboviruses, including, but not limited to, the following:

- (A) St. Louis.
- (B) California group.
- (C) Eastern equine.
- (D) Western equine.
- (E) West Nile.
- (F) Japanese B.
- (G) Yellow fever.

- (2) *Babesia* species.
- (3) *Bacillus anthracis*.
- (4) *Bordetella pertussis*.
- (5) *Borrelia burgdorferi*.
- (6) *Brucella* species.
- (7) *Calymmatobacterium granulomatis*.
- (8) *Campylobacter* species.
- (9) *Chlamydia psittaci*.
- (10) *Chlamydia trachomatis*.
- (11) *Clostridium botulinum*.
- (12) *Clostridium perfringens*.
- (13) *Clostridium tetani*.

- (14) *Corynebacterium diphtheriae*.
- (15) *Coxiella burnetii*.
- (16) *Cryptococcus neoformans*.
- (17) *Cryptosporidium parvum*.
- (18) *Cyclospora cayetanensis*.
- (19) *Ehrlichia chaffeensis*.
- (20) *Ehrlichia phagocytophila*.
- (21) Enteroviruses (coxsackie, echo, polio).
- (22) *Escherichia coli* infection (including *E. coli* 0157:H7 and other enterohemorrhagic types).
- (23) *Francisella tularensis*.
- (24) *Haemophilus ducreyi*.
- (25) Hantavirus.
- (26) Hepatitis viruses:
 - (A) anti-HAV IgM;
 - (B) HbsAg or HbeAg or anti-HBc IgM;
 - (C) RIBA or RNA or Anti-HCV, or any combination
 - (D) Delta.
- (27) *Haemophilus influenzae*, invasive disease.
- (28) *Histoplasmosis capsulatum*.
- (29) HIV and related retroviruses.
- (30) Influenza.
- (31) Kaposi's sarcoma (biopsies).
- (32) *Legionella* species.
- (33) *Leptospira* species.
- (34) *Listeria monocytogenes*.
- (35) Measles virus.
- (36) Mumps virus.
- (37) *Mycobacterium tuberculosis*.
- (38) *Neisseria gonorrhoeae*.
- (39) *Neisseria meningitidis*, invasive.
- (40) Pediatric blood lead tests (capillary and venous) equal to or greater than 10 $\mu\text{g/dl}$ on children less than or equal to six (6) years of age.
- (41) *Plasmodium* species.
- (42) *Pneumocystis carinii*.
- (43) Rabies virus (animal or human).
- (44) *Rickettsia* species.
- (45) Rubella virus.
- (46) *Salmonella* species.
- (47) *Shigella* species and antimicrobial resistance pattern.
- (48) *Staphylococcus aureus*, Vancomycin resistance equal to or greater than 8 $\mu\text{g/mL}$.
- (49) *Streptococcus pneumoniae*, invasive disease, and antimicrobial resistance pattern.
- (50) *Streptococcus* Group A (*Streptococcus pyogenes*), invasive disease.
- (51) *Streptococcus* Group B, invasive disease.
- (52) *Treponema pallidum*.

- (53) *Trichinella spiralis*.
- (54) *Vibrio* species.
- (55) *Yersinia* species, including *pestis*, *enterocolitica*, and *pseudotuberculosis*.

(e) Laboratories may also report to the local health officer, but any such local report shall be in addition to reporting to the department. A laboratory may report by electronic data transfer, telephone, or other confidential means of communication. In lieu of electronic data transfer or reporting by telephone, a laboratory may submit a legible copy of the laboratory report, provided that the information specified in subsection (b) appears thereon. Whenever a laboratory submits a specimen, portion of a specimen, or culture to the department laboratory resource center for confirmation, phage typing, or other service, these reporting requirements will be deemed to have been fulfilled, provided that the minimum information specified in subsection (b) accompanies the specimen or culture.

(f) Laboratories shall submit all isolates of the following organisms to the department's microbiology laboratory for further evaluation:

- (1) *Haemophilus influenzae*, invasive disease.
- (2) *Neisseria meningitidis*, invasive disease.
- (3) *E. coli* 0157:H7 or sorbitol-negative *E. coli* isolates.
- (4) *Staphylococcus aureus*, Vancomycin resistance equal to or greater than 8 µg/mL.
- (5) *Mycobacterium tuberculosis*.
- (6) *Listeria monocytogenes*.
- (7) *Salmonella* from any site.

(g) Quarterly report the total number of blood lead test (capillary and venous) performed on children 6 or less years of age.

(h) Reporting by a laboratory, as required by this section, shall not:

- (1) constitute a diagnosis or a case report; and
- (2) be considered to fulfill the obligation of the attending physician or hospital to report.

(i) Failure to report constitutes a Class A infraction as specified by IC 16-41-2-8.

Public Health Interventions

Responsibility to investigate and implement

Sec. 49. (a) Case reports submitted to the local health department or the department may be used for epidemiological investigation or other disease intervention activities as warranted. Prior approval from a patient is not required before releasing medical or epidemiological information to the local health department or the department.

(b) Unless otherwise indicated, the local health department in the jurisdiction where the patient is a resident is responsible for performing any epidemiological investigation required and instituting control measures.

(c) Upon receiving a communicable disease report, local health officers must investigate the

report within a reasonable time frame, immediately for diseases that shall be reported immediately, but usually not more than seventy-two (72) hours after the report is received for other diseases.

(d) Investigation shall include obtaining laboratory and clinical data necessary for case ascertainment. Investigation efforts should identify all potential means for disease acquisition, risk factors, and any potential public health threats posed by the case. Findings of the investigation shall be used to institute control measures to minimize or abrogate the risk of disease spread.

(e) The results of the investigation shall be documented, in writing, with a copy maintained at the local health department, and a copy forwarded to the department communicable disease section. Local health departments that do not have the necessary security to maintain complete confidentiality of HIV/AIDS patients may defer the storage of all copies to the department.

(f) The department may request and obtain epidemiological information on cases of communicable disease or diseases of public health importance, including diseases caused by drug-resistant organisms and emerging infectious diseases.

(g) Medical or epidemiological information, wherever maintained, concerning reportable cases, shall be made available to the commissioner or the commissioner's designee.

Confidentiality of medical and epidemiological information

Sec. 50. (a) All information obtained pursuant to this rule, whether from patient records or other sources, is confidential as specified by IC 16-41-8-1(a).

(b) Except as provided in subsection (a), a person responsible for recording, reporting, or maintaining information required to be reported under IC 16-41-2 who recklessly, knowingly, or intentionally discloses or fails to protect medical or epidemiological information classified as confidential under this section commits a Class A misdemeanor.

(c) In addition to subsection (b), a public employee who violates this section is subject to discharge or other disciplinary action under the personnel rules of the agency that employs the employee.

(d) Release shall be made of the medical records concerning an individual to the individual or to a person authorized in writing by the individual to receive the medical records.

(e) An individual may voluntarily disclose information about the individual's communicable disease.

(f) The provisions of this section regarding confidentiality apply to information obtained under IC 16-41-1 through IC 16-41-16. For purposes of compliance with the confidentiality provisions of IC 34-3-15.5-6(h), only the following diseases and conditions shall be defined as dangerous communicable diseases:

- (1) Acquired immunodeficiency syndrome.
- (2) *Gonorrhea*.
- (3) Hepatitis, viral.
- (4) HIV infection/disease.
- (5) Syphilis.
- (6) Chancroid.
- (7) *Chlamydial* (genital) infections.
- (8) Lymphogranuloma venereum.
- (9) Information regarding all other diseases and conditions listed in section 47 of this rule, and not listed in this subsection, may be released as authorized by IC 34-3-15.5-6.

General control measures

Sec. 51. General control measures are as follows:

- (1) A local health officer or the commissioner, upon being notified of the existence of any communicable disease covered by a specific control measure in this section shall ensure that the procedures required under the rule for the specific disease are carried out.
- (2) A local health officer or the commissioner, upon learning or being notified of communicable diseases that are not covered by any specific control measures in this section, shall place such restrictions upon the movements of cases or carriers and their contacts as may be reasonably necessary to prevent the spread of disease. Specific control measures for the selected diseases or conditions are listed in sections 52 through 112 of this rule. For control measures for diseases or conditions not listed insofar as applicable, the procedures prescribed in the Control of Communicable Diseases Manual, 17th Edition, 2000, a publication of the American Public Health Association, shall be followed to the extent that they are not in conflict with the laws of Indiana or this rule. In addition, the procedures implemented by the local health officer or the commissioner shall include provisions for proper hand washing procedures and universal precautions as defined in this rule.
- (3) A local health officer, upon notification of the occurrence of a disease that is required by sections 47 and 48 of this rule to be reported immediately, shall in turn notify the department immediately by telephone or other instantaneous means of communication.
- (4) A local health officer, in receipt of reports required by sections 47 and 48 of this rule to be reported in either seventy-two (72) hours or one (1) week, shall, on each Friday, or if Friday is a holiday, the previous business day, forward to the department electronic or paper copies of reports received during the previous seven (7) days and not yet forwarded. Upon suspicion of an outbreak, the local health officer shall notify the department immediately, by telephone or other instantaneous means of communication. More frequent reports shall be furnished during an outbreak as required by the department.
- (5) A local health officer in receipt of a report of a disease that is potentially dangerous to the public health, or of national or international significance not listed as a reportable disease in section 47 or 48 of this rule, shall notify the department immediately by telephone or other confidential means of communication to establish reporting requirements for additional reports of that disease that subsequently may be received by the local health officer.
- (6) The local health officer or the commissioner shall make an attempt to seek cooperation of

cases, carriers, contacts, or suspect cases to implement the least restrictive, but medically necessary, procedures to protect the public health. Those procedures may include, but not be limited to:

- (A) participate in a designated education, counseling, or treatment program;
- (B) undergo confirmatory testing;
- (C) undergo medically accepted tests or treatments that are consistent with standard medical practice as necessary to make the case or carrier noninfectious;
- (D) notify or appear before designated health officials for verification of disease status at periodic times;
- (E) cease and desist conduct that constitutes a health threat to others;
- (F) be monitored by an electronic monitoring device to prevent activities that constitute a health threat to others;
- (G) live part time or full time in a supervised setting;
- (H) be confined to an appropriate hospital, home, apartment, or other institutional facility or residential setting; or
- (I) comply with any combination of the remedies under this subdivision considered appropriate by the health officer.

Disease Specific Control Measures

Sec. 52. Animal bites. (a) The specific control measures for animal bites are as follows:

(1) Every case of a human bitten by a domestic or wild mammal shall be reported promptly to the local health officer or his or her designee having jurisdiction. If a physician is in attendance, such physician shall report the bite. If no physician is in attendance and the person bitten is a child, it shall be the duty of the parent or the guardian to make such a report immediately. If the person bitten is an adult, such person shall make the report or, if incapacitated, the bite shall be reported by whoever is caring for the person bitten. It shall be the duty of the local health officer to report information concerning the bite on the prescribed form. The report shall include requested information on postexposure rabies prophylaxis if it is being administered to the bite victim. Each reported bite shall be investigated immediately by the local health officer or a designee. This investigation shall be conducted with the purpose of determining the need for postexposure rabies prophylaxis of the bite victim and either:

- (A) imposing a ten (10) day observation period on the biting animal (dog, cat, or ferret only) to determine if the animal was capable of transmitting rabies at the time of the biting incident; or
- (B) submission of the head, if the biting animal is a potential rabies vector, to the department laboratory to determine if it was infected with rabies.

(2) Isolation is not necessary.

(3) Concurrent disinfection is not necessary.

(4) Quarantine shall be applied as follows:

- (A) Any apparently healthy dog, cat, or ferret that has bitten a person, or any dog, cat, or ferret suspected of being rabid shall be confined and held in observation for the period specified in IC 15-2.1-6-11 (not less than ten (10) days) or humanely killed at once for

laboratory examination. Such confinement shall be under the supervision of the state veterinarian or a licensed, accredited veterinarian, or other person designated by the official quarantining the animal, and at the expense of the owner.

(B) Any illness in the confined dog, cat, or ferret shall be reported immediately to the local health department. Animals under confinement shall not be immunized against rabies during the observation period. The head of any such dog, cat, or ferret that dies during the period of observation, or is killed subsequent to having bitten a person or another animal, shall be removed, packed in an iced container, but not frozen, and forwarded immediately to the laboratory of the department for rabies testing.

(C) Any stray, unwanted, or unhealthy dog, cat, or ferret that has bitten a person shall be humanely killed immediately for laboratory examination. The animal's owner shall be responsible for having the unwanted or unhealthy animal euthanized, head removed, and shipped to the department for rabies examination. In the case of a stray animal or an animal whose owner cannot be found, the local health department or its designee shall assume this responsibility.

(D) Any potentially rabid wild mammal that has bitten a human or a domestic animal, or is suspected of being rabid, shall not be placed under observation, but shall be humanely killed at once in a manner that does not cause trauma to the head or brain. The head shall be refrigerated, but not frozen, and submitted within forty-eight (48) hours to the laboratory of the department. Wild mammals include, but are not limited to, the following:

(i) Wild animals kept as pets.

(ii) Wild mammals crossbred to domestic dogs and cats.

(E) The bite victim shall be notified after a dog, cat, or ferret has passed the ten (10) day observation period in a healthy state or after the results of a laboratory test are available.

(F) Any person bitten or scratched by a wild carnivorous mammal or bat not available for rabies testing should be regarded as having been potentially exposed to rabies. The following chart provides information on quarantine and disposition of biting animals.

Animal Type	Evaluation and Disposition of Animal	Postexposure Prophylaxis Recommendation
Dogs, cats, and ferrets	Healthy and available for 10 day observation ¹	Should not begin prophylaxis unless animal develops symptoms of rabies ²
	Rabid or suspected rabid	Immediate postexposure prophylaxis
	Unknown	Consult public health officials
Skunks, raccoons, bats ³ , foxes, and most other carnivores; woodchucks and wild animals kept as pets	Regard as rabid unless geographic area is known to be free of rabies or until animal proven negative by laboratory testing ⁴	Immediate postexposure prophylaxis or if animal available for testing, as soon as positive result is observed

Livestock, rodents, and lagomorphs (rabbits and hares)	Consider individually	Consult public health officials. Bites of squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice, other rodents, rabbits, and hares almost never require antirabies treatment.
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¹ Stray dogs and cats may be euthanized immediately and their heads submitted to the rabies laboratory.

² Postexposure prophylaxis should be started if a veterinarian identifies an animal as being symptomatic. Symptomatic animals should be euthanized and tested immediately.

³ What appears to be insignificant contact with bats may result in rabies transmission, even without clear evidence of a bite. Postexposure prophylaxis is recommended for all persons with bite, scratch, or mucous membrane exposure to a bat unless the bat is available for testing and is negative for rabies. Postexposure prophylaxis is appropriate even in the absence of bite, scratch, or mucous membrane exposure in situations in which there is a reasonable probability that such contact occurred (for example, a sleeping individual awakes to find a bat in the room, an adult witnesses a bat in the room with a previously unattended child, mentally challenged person, or intoxicated person) and rabies cannot be ruled out by testing the bat.

⁴ The animal should be killed and tested as soon as possible. Holding for observation is not recommended as time lapse from virus secretion in saliva until clinical symptoms appear have not been determined for species other than a dog, cat, and ferret. Consult with the department veterinary epidemiologist for information on presence or absence of rabies in particular species.

(b) All bite wounds should be treated immediately in the following steps:

- (1) Clean and flush wound as first aid.
- (2) Thorough wound cleansing under medical supervision.
- (3) Evaluation of need for postexposure prophylaxis.
- (4) Tetanus prophylaxis and antibacterial treatment as required.

(c) If the decision is made to provide postexposure prophylaxis to the individual, the following protocols must be followed, and a decision to provide postexposure prophylaxis must be reported to the department:

Guidelines for Postexposure Prophylaxis		
Vaccination Status	Treatment	Regimen*
Not previously vaccinated	Local wound cleaning	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.

	Human rabies immune globulin (HRIG)	20 IU/kg body weight. If anatomically feasible, the full dose should be infiltrated around the wound or wounds. Any remaining volume should be administered intramuscularly at a site distant from vaccine inoculation.
	Vaccine	Human diploid cell vaccine (HDCV), purified chick embryo cell vaccine (PCEC), or rabies vaccine adsorbed (RVA), 1.0 ml, IM (deltoid ¹), 1 each on days 0, 3, 7, 14, and 28.
Previously vaccinated ²	Local wound cleaning	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.
	HRIG	Should not be administered.
	Vaccine	HDCV, PCEC, or RVA, 1.0 ml IM (deltoid ¹), 1 each on days 0 and 3.

*These regimens are applicable for all age groups, including children.

¹ The deltoid area is the only acceptable site of vaccination for adults and older children. For younger children, the outer aspect of the thigh may be used. The vaccine should never be administered in the gluteal area.

² Any person with a history of preexposure vaccination with HDCV or RVA; prior postexposure prophylaxis with HDCV or RVA; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to the prior vaccination.

Sec. 53. Anthrax. The specific control measures for anthrax (infectious agent: *Bacillus anthracis*) are as follows:

- (1) Immediate investigation by the local health officer shall be accomplished to determine the source of exposure. History of exposure to animals and animal products (wool, hair, or raw leather), and travel to endemic anthrax areas shall be fully investigated.
- (2) Standard precautions for isolation of hospitalized patients shall be followed.
- (3) Discharges from lesions and articles contaminated with discharges require disinfection. An infectious agent is a spore former that will survive in environment for long periods. Disinfection requires sporicidal agent.
- (4) Quarantine is not necessary.
- (5) If exposure occurred in an occupational/industrial setting, a review of industrial hygiene practices shall be made to reduce risk of other cases.

Sec. 54. Babesiosis. The specific control measures for babesiosis (infectious agent: *Babesia* species) are as follows:

- (1) The local health officer shall perform an investigation within seventy-two (72) hours. The investigation shall focus on source of exposure to infected ticks or recent blood transfusions. Travel history for the previous six (6) months to include the most recent summer months is essential.
- (2) Isolation is not required.
- (3) Concurrent disinfection is not required.
- (4) Quarantine is not required.
- (5) Immunizations are not available. Household contacts or traveling companions with similar exposures should also be evaluated for infection. If the patient donated blood while incubating the disease, the blood collecting agency should be notified.

Sec. 55. Botulism. The specific control measures for botulism (infectious agent: *Clostridium botulinum*) are as follows:

- (1) An investigation shall be performed immediately. The purpose of the investigation shall be case ascertainment, assurance of availability of polyvalent (equine ABE) antitoxin, and identification of infection source. The local health officer shall obtain a five (5) day food history of those ill, in addition to a fourteen (14) day wound history. The local health officer shall also recover all suspected foods for appropriate testing and disposal. If suspicion is high that the source is a commercial food product or a product served in a restaurant, the local health officer shall perform active surveillance to identify additional cases.
- (2) Isolation is not required.
- (3) Implicated food shall be detoxified by boiling before discarding, or containers broken and buried deeply to prevent ingestion by animals. Contaminated environmental surfaces shall be sterilized by boiling, or by chlorine disinfection to inactivate any remaining toxin. Feces from infant cases may be disposed of in a sanitary sewer. Terminal cleaning shall also be followed.
- (4) Polyvalent (equine ABE) antitoxin may be given to asymptomatic individuals within one (1) to two (2) days of consuming implicated foods, but must be weighed against the risk of adverse reaction and sensitization to horse serum.

Sec. 56. Brucellosis. The specific control measures for *brucellosis* (infectious agent: *Brucella* species) are as follows:

- (1) An investigation to trace infection to the common or individual source, usually:
 - (A) infected dogs, domestic goats, swine, or cattle; or
 - (B) unpasteurized milk or dairy products (cheese) from cows and goats;shall be conducted by the local health officer. Occupational exposures from slaughterhouses or others working with infected animal tissues or products should be considered. Animals suspected of being infected shall be managed according to requirements of the Indiana state board of animal health.
- (2) Standard precautions for hospitalized patients shall be taken.
- (3) Concurrent disinfection of purulent discharges shall be followed.
- (4) Quarantine is not required.
- (5) Protection or immunization of contacts is not required.

Sec. 57. Campylobacter. The specific control measures for *Campylobacter* enteritis (infectious agent: *Campylobacter* species) are as follows:

- (1) An investigation by the local health officer shall include a five (5) day food history and history of exposure to pets, farm animals, or infected infants.
- (2) Contact precautions shall be followed for diapered or incontinent individuals or children less than six (6) years of age, otherwise use standard precautions. For others, the following guidelines apply:
 - (A) Symptomatic persons shall be excluded from employment involving food handling, or direct care of children or hospitalized or institutionalized patients.
 - (B) Asymptomatic food handlers, day care workers, or health care workers may be released to return to work provided the following activities have taken place prior to that person's return to work:

- (i) The local health officer or his or her designee discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.
- (ii) The local health officer or his or her designee contacts the employer to reemphasize the need to comply with local and state rules requiring proper hand washing facilities for all employees, and to correct any observed lapses in hygienic measures of any employees.
- (C) Symptomatic persons shall be excluded from schools and day care centers. Asymptomatic persons may be released to return to school or day care after the local health officer or his or her designee has discussed with the appropriate school or day care center staff the need for proper hand washing and other infection control practices, and the need to comply with all local and state rules pertaining to prevention of infectious diseases.
- (D) If an outbreak of the infection occurs among staff or attendees in a day care center, all attendees may be required to submit stool specimens for examination. In addition, all asymptomatic attendees and staff who are infected with *Campylobacter* may need to be isolated from other attendees and staff in the same day care center and admission of all new attendees suspended while the outbreak continues.
- (3) Concurrent disinfection of feces and soiled articles is required. Feces may be discharged in a sanitary sewer without prior disinfection.
- (4) Quarantine is not required.
- (5) Protection/immunization is not available.

Sec. 58. Chancroid. The specific control measures for chancroid (infectious agent: *Haemophilus ducreyi*) are as follows:

- (1) An investigation shall be accomplished by the local health officer and shall be focused on identifying sexual partners who were at risk for transmitting to, or contracting the infection from the case. Case and contacts shall be fully evaluated and treated as recommended in the MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1.
- (2) Standard precautions are required. Avoid sexual contact until all lesions are healed.
- (3) Concurrent disinfection is not required.
- (4) Quarantine is not required.
- (5) Sexual contacts shall receive prophylactic treatment. Immunization is not available.

Sec. 59. *Chlamydia*. The specific control measures for *chlamydial* infections, genital, (infectious agent: *Chlamydia trachomatis*) (See Psittacosis for infections caused by *Chlamydia psittaci*) are as follows:

- (1) An investigation shall be accomplished by the local health officer and shall be focused on identifying sexual partners who were at risk for transmitting to, or contacting the infection from the case. Case and contacts shall be fully evaluated and treated as recommended in the MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1.
- (2) For hospital patients, standard precautions shall be followed. Appropriate antibiotic therapy renders discharges noninfectious; patients shall refrain from sexual intercourse until treatment is completed.
- (3) Careful disposal of articles contaminated with urethral and vaginal discharges is required.
- (4) Quarantine is not required.
- (5) Immunization is not available.

Sec. 60. *Cholera*. The specific control measures for Cholera (infectious agent: *Vibrio cholerae*) are as follows:

- (1) Immediate investigation by the local health officer shall include food and water consumption history for patients for five (5) days prior to illness, as well as travel history. Interview individuals who consumed food and water with the patient to identify additional cases, and determine the contaminated food or water source. If suspicion centers on water, a commercial food product, or a restaurant as a potential source, active surveillance shall be carried out to identify additional cases.
- (2) For hospitalized individuals, standard precautions shall be followed with the addition of contact precautions for diapered or incontinent children less than six (6) years of age for duration of illness.
- (3) Feces, vomitus, and articles soiled by feces or vomitus, or both, shall receive concurrent disinfection. Feces and vomitus can be discharged directly in a sanitary sewer system.
- (4) Quarantine is not required.
- (5) Observe individuals who consume food and drink from the same sources as the patient for five (5) days from the last exposure. In household where secondary transmission is highly likely, antimicrobial therapy with either tetracycline or doxycycline should be provided. Immunization of contacts is not beneficial.

Sec. 61. *Cryptosporidiosis*. The specific control measures for *cryptosporidiosis*, (infectious agent: *Cryptosporidium* species) are as follows:

- (1) The local health officer shall determine if the case is a food handler, day care worker, or health care worker or day care attendee. Additional investigation shall include a seven (7) day food history, history of exposure to day care or preschool children, pets or domestic animals, or exposure to surface water. If suspicion centers on a commercial food product, restaurant, or public water supply, active surveillance shall be instituted to identify additional cases.

(3) For hospitalized individuals, standard precautions shall be followed with the addition of contact precautions for diapered or incontinent children less than six (6) years of age for the duration of the illness. For others, the following instructions apply:

(A) Symptomatic persons shall be excluded from employment involving food handling or the direct care of children or hospitalized or institutionalized patients.

(B) Asymptomatic food handlers, day care workers, or health care workers may be released to return to work, providing the following activities have taken place prior to that person's return to work:

(i) The local health officer or his or her designee discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic, and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of the disease.

(ii) The local health officer or his or her designee contacts the employer to:

(AA) reemphasize the need to comply with local and state rules requiring proper hand washing facilities for all employees; and

(BB) correct any observed lapses in hygienic measures of any employees.

(C) Symptomatic persons shall be excluded from schools and day care centers.

(D) Asymptomatic persons may be released to return to school or day care after the local health officer or his or her designee has discussed with appropriate school or care center staff the need:

(i) for proper hand washing and other infection control practices; and

(ii) to comply with all local and state rules pertaining to prevention of infectious diseases.

If an outbreak of the infection occurs in a day care center, all attendees may be required to submit stool specimens for examination. In addition, all asymptomatic attendees and staff who are infected with *Cryptosporidium* may need to be isolated from other attendees and staff in the same center, and admission of all new attendees suspended while the outbreak continues.

(3) Concurrent disinfection of feces and feces soiled articles is required. Feces may be disposed of in a sanitary sewer system.

(4) Quarantine is not required.

(5) Vaccination is not available.

Sec. 62. *Cyclospora*. The specific control measures for *Cyclospora* species are as follows:

(1) Within seventy-two (72) hours of receiving the report, the local health officer shall investigate the case to include a seven (7) day food history, exposure to water, and travel. Use individual case investigation to detect outbreaks and identify potential sources. If a commercial food source is suspected, active surveillance shall be undertaken.

(2) For hospitalized individuals, standard precautions shall be followed with the addition of contact precautions for diapered or incontinent children less than six (6) years of age for the duration of the illness. For others, the following instructions apply:

(A) Symptomatic persons shall be excluded from employment involving food handling or the direct care of children or hospitalized or institutionalized patients.

(B) Asymptomatic food handlers, day care workers, or health care workers may be released to return to work, provided the following activities have taken place prior to that person's return

to work:

(i) The local health officer or his or her designee discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic, and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.

(ii) The local health officer or his or her designee contacts the employer to:

(AA) reemphasize the need to comply with local and state rules requiring proper hand washing facilities for all employees; and

(BB) correct any observed lapses in hygienic measures of any employees.

(C) Symptomatic persons shall be excluded from schools and day care centers.

(D) Asymptomatic persons may be released to return to school or day care after the local health officer or his or her designee has discussed with appropriate school or care center staff the need:

(i) for proper hand washing and other infection control practices; and

(ii) to comply with all local and state rules pertaining to prevention of infectious diseases.

If an outbreak of the infection occurs in a day care center, all attendees may be required to submit stool specimens for examination. In addition, all asymptomatic attendees and staff who are infected with *Cyclospora* may need to be isolated from other attendees and staff in the same center, and admission of all new attendees suspended while the outbreak continues.

(3) Concurrent disinfection of feces and feces soiled articles is required. Feces may be disposed of in a sanitary sewer.

(4) Quarantine is not required.

Sec. 63. Diphtheria. The specific control measures for diphtheria (infectious agent: *Corynebacterium diphtheriae*) shall be implemented immediately and are as follows:

(1) A trained immunization field representative of the department, in cooperation with local health officers, shall perform an investigation and case management of diphtheria cases. All investigation activities shall be performed immediately and shall include (at a minimum) determination of immunization status of the index case or suspect case. Culture shall be obtained for organism identification. A complete list of contacts shall be generated. Contacts are defined as all individuals in the household, all individuals with a history of habitual, close contact, and all individuals directly exposed to throat and nasal secretions of the patient.

(2) For hospitalized patients, institute droplet precautions for pharyngeal diphtheria and contact precautions for cutaneous diphtheria. Continue precautions until the patient is off antibiotics and two (2) cultures taken twenty-four (24) hours apart are negative.

(3) Concurrent disinfection is required for:

(A) articles in contact with the patient; and

(B) all articles soiled by the patient's discharges.

(4) Contacts who are food handlers, child care providers, or health care workers shall be excluded from work until bacteriologic examination proves them not to be carriers.

(5) Close contacts, regardless of immunization status shall be observed for seven (7) days for signs, symptoms of disease, cultured for *C. diphtheriae*, and treated prophylactically with oral erythromycin (forty (40) to fifty (50) milligram per kilogram per day (mg/kg/day) for seven (7) days, two (2) grams per day (gm/day) maximum), or given a single intra muscular (IM) dose of

benzathine penicillin G (six hundred thousand (600,000)) units (U) for those less than thirty (30) kg and one million two hundred thousand (1,200,000) U for older children and adults). For individuals who are culture positive, repeat cultures after completion of therapy. Previously immunized asymptomatic close contacts should receive a booster dose of diphtheria toxoid if five (5) years have lapsed since the last immunization. Individuals incompletely immunized or with unknown immunization status should start an active immunization series with a diphtheria toxoid preparation appropriate for age.

(6) Treatment of individuals suspected of having diphtheria should not be delayed awaiting culture results. Diphtheria antitoxin should be given based on clinical diagnosis. Antitoxin dosage is dependent on length and severity of the disease. Antimicrobial therapy is essential to eliminate organism, and to prevent the spread of the disease, as follows:

(A) Erythromycin (forty (40) to fifty (50) mg/kg/day, maximum two (2) grams per day (gm/d)) given orally or parenterally for fourteen (14) days.

(B) Penicillin G given parenterally (aqueous crystalline, one hundred thousand (100,000) to one hundred fifty thousand (150,000) units per kilogram per day (U/kg/day), in four (4) divided doses intra venous (IV)).

(C) Aqueous procaine penicillin, (twenty-five thousand (25,000) to fifty thousand (50,000) U/kg/day, maximum one million two hundred thousand (1,200,000) units intra muscular (IM) in two (2) divided doses) for fourteen (14) days are the recommended therapy.

(D) Penicillin V per os (PO) (one hundred twenty four (124) to two hundred fifty (250) mg four (4) times daily) for fourteen (14) days.

Sec. 64. Ehrlichiosis. The specific control measures for ehrlichiosis, (infectious agent: *Ehrlichia chaffeensis* or other *Ehrlichia* species) are as follows:

(1) Interview the patient to determine exposure to ticks and the location of exposure for the previous four (4) weeks. Information gathered is useful in identifying foci of infected environments and public education campaigns on prevention.

(2) Standard precautions are required.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required.

Sec. 65. Arboviral Encephalitis. The specific control measures for arboviral encephalitis (California, eastern equine encephalitis, western equine encephalitis, and St. Louis encephalitis) are as follows:

(1) The local health officer shall investigate immediately for the purpose of identifying location and presence of vector mosquitoes. Active surveillance shall be instituted. The local health department shall identify areas in the community where there is a need for vector control. Identification of cases in horses, birds, or humans or both provides evidence of virus presence and amplification in the community environment.

(2) Use contact precautions until enterovirus meningoencephalitis is eliminated from list of possible diagnoses.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required.

(5) Protection or immunization of contacts is not required for individuals. Fogging or spraying

insecticides have been effectively used to abort urban epidemics and may be recommended by the department.

Sec. 66. *E. Coli* 0157:H7. The specific control measures for diarrhea and hemolytic uremic syndrome associated *E. coli* infection (including *E. coli* 0157:H7), (infectious agent: *Escherichia coli* (including serotype 0157:H7)) are as follows:

(1) An investigation by the local health officer shall be accomplished immediately to determine if the affected individual is part of an outbreak and if he or she is a food handler, day care attendant, health care worker, day care attendee, or attendee at a school or other institution. Further investigation shall be performed to determine a seven (7) day food consumption history with an emphasis on the consumption of beef products and raw vegetables, unpasteurized fruit juices or milk, or exposure to potentially contaminated water, either by swimming or consumption. Interview meal companions for additional cases and if a commercial food product or restaurant is suspected, conduct active surveillance for additional cases. Medical evaluation, including adequate laboratory examination of feces of contacts should be limited to food handlers, child care attendants, health care workers, or other situations where outbreaks may occur.

(2) For hospitalized individuals, standard precautions shall be followed with the addition of contact precautions for diapered or incontinent patients for the duration of the illness and until two (2) successive stool cultures taken no less than twenty-four (24) hours apart and no sooner than forty-eight (48) hours after the cessation of antibiotic therapy are negative for the presence of *E. coli* 0157:H7 organisms. For others, the following steps shall be taken:

(A) Symptomatic persons shall be excluded from employment involving food handling or the direct care of children or hospitalized or institutionalized patients.

(B) Asymptomatic food handlers, day care workers, and health care workers may return to work, provided the following have taken place prior to that person's return to work:

(i) The local health officer discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic, and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.

(ii) The local health officer contacts the employer to reemphasize the need to comply with local and state rules requiring proper hand washing facilities for all employees, and to correct any observed lapses in hygiene measures of any employees.

In addition, asymptomatic food handlers will be restricted from working with exposed food, clean equipment, utensils, linens, unwrapped single-service, and single-use articles until two (2) successive stool cultures taken no less than twenty-four (24) hours apart and no sooner than forty-eight (48) hours after the cessation of antibiotic therapy are negative for the presence of *E. coli* 0157:H7 organisms.

(C) Infected children shall be excluded from any day care setting (including, but not limited to, babysitting groups and preschools) until two (2) successive stool cultures taken no less than twenty-four (24) hours apart and no sooner than forty-eight (48) hours after the cessation of antibiotic therapy are negative for the presence of *E. coli* 0157:H7 organisms. It is imperative that parents of infected children understand the potential consequences of this disease, its modes of transmission, and the absolute necessity for strict attention to personal

hygiene. It is imperative that excluded children not be transferred to another child care setting until such time as they are determined to be clear of organisms.

(D) If an outbreak occurs in a day care center or preschool, all attendees and staff may be required to submit stool specimens for examination. Rather than expulsion until stool-negative, the day care administrator may consider isolation of asymptomatic infected attendees from other attendees. This alternative can only be considered if the physical structure and staff organization of the center can accommodate isolation of various groups from one another. If this alternative is selected, increased emphasis on hand washing and environmental cleaning is necessary. Day care centers shall be closed to new admissions until such time as health officials determine that the outbreak is over.

(E) Symptomatic children shall be excluded from school until asymptomatic and the following activities have taken place prior to the student's return to school:

(i) The local health officer discusses with the asymptomatic student and parents his or her symptoms and determines that he or she is indeed asymptomatic, and that the student is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.

(ii) The local health officer contacts the local school administration to reemphasize the need to comply with local and state rules requiring proper hand washing facilities and the need to emphasize good hand washing practices of the students.

(3) Concurrent disinfection of feces and fecal soiled articles is required. Feces may be disposed of directly in a sanitary sewage system.

(4) Quarantine is not required.

(5) Protection or immunization of contacts is not required.

Sec. 67. Gonorrhea. The specific control measures for gonorrhea, (infectious agent: *Neisseria gonorrhoeae*), are as follows:

(1) Investigation shall be accomplished by the local health officer and shall be focused on identifying sexual partners who were at risk for transmitting to, or contacting the infection from, the case. Case and contacts shall be fully evaluated and treated as recommended in the MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1.

(2) Standard precautions shall be instituted for hospitalized individuals. Infected persons shall not engage in sexual activities involving the exchange of body fluids until therapy is completed and they no longer have symptoms. Treated persons shall also refrain from sexual activities involving the exchange of body fluids with untreated previous sexual partners to avoid reinfection. Cases should be examined serologically for syphilis.

(3) Concurrent disinfection is required for articles contaminated with discharges.

(4) Quarantine is not required.

(5) Immunization is not available.

Sec. 68. Granuloma Inguinale. The specific control measures for Granuloma inguinale (infectious agent: *Calymmatobacterium granulomatis*) are as follows:

(1) An investigation shall be accomplished by the local health officer and shall be focused on identifying sexual partners who were at risk for transmitting to, or contacting the infection

from, the case. Case and contacts shall be fully evaluated and treated as recommended in the MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1.

(2) Standard precautions for hospitalized patients are required. Patients shall refrain from sexual activities until treatment is complete and lesions are healed. Patients shall refrain from sexual activities with untreated previous sexual partners.

(3) Concurrent disinfection is required for discharges from lesions and articles soiled by those discharges.

(4) Quarantine is not required.

(5) No immunization is available. Prompt treatment of contacts upon recognition or suspicion of disease is required.

Sec. 69. *Haemophilus Influenzae*. The specific control measures for *Haemophilus influenzae* Type B invasive disease (including bacteremia, meningitis, epiglottitis, septic arthritis, cellulitis, pericarditis, endocarditis, and osteomyelitis), (infectious agent: *Haemophilus influenzae*) are as follows:

(1) An investigation and case management shall be performed immediately by department-trained immunization field representatives in cooperation with the local health officer. The investigation shall include an immunization history of the index case, and identification of all contacts under four (4) years of age. Contacts are defined as household, child care, and nursery school contacts, or individuals who spent four (4) or more hours with the index case for at least five (5) of the seven (7) days preceding the onset of the illness.

(2) Droplet precautions shall be followed for twenty-four (24) hours after the start of chemotherapy.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required.

(5) With the exception of pregnant females, rifampin prophylaxis (orally once daily for four (4) days in 20 mg/kg dose, maximal dose 600mg/day) should be administered to the following:

(A) All members of a household where there is one (1) or more children younger than twelve (12) months should receive prophylaxis.

(B) All members of a household where there are contacts under forty-eight (48) months of age with incomplete immunization status should receive prophylaxis.

(C) Attendees and supervisory personnel in a child care facility where unvaccinated or incompletely vaccinated children are in attendance, and where two (2) cases of invasive *Haemophilus influenzae* have occurred within sixty (60) days.

(D) Prophylaxis of a single case in child care facilities is controversial; consult current recommendations.

(E) The index case should receive rifampin prior to discharge if he or she was not treated with cefotaxime or ceftriaxone.

(F) Parents and child care providers of contacts should be educated about signs and symptoms of *Haemophilus influenzae* disease.

Sec. 70. Hansen's Disease. The specific control measures for Hansen's disease (infectious agent: *Mycobacterium leprae*) are as follows:

- (1) The local health officer shall assure that initial and periodic examination of household contacts occur at twelve (12) month intervals for at least five (5) years after the last contact with infectious patient.
- (2) Standard precautions for hospitalized patients are required.
- (3) Concurrent disinfection is required for nasal discharges and articles soiled with nasal discharges from patients considered infectious.
- (4) Household contact of patients with borderline or lepromatous leprosy who are less than twenty-five (25) years of age should be treated prophylactically with dapsone for three (3) years at the same doses as for treatment.

Sec. 71. Hantavirus. The specific control measures for hantavirus are as follows:

- (1) An investigation shall be immediately conducted by the local health officer for the purpose of case ascertainment and identification of the source of infection. The investigation shall be to identify the source of exposure to rodent feces and urine. Exterminate rodents at suspected site of infection, and disinfect environmental surfaces.
- (2) Standard precautions are required.
- (3) Concurrent disinfection is not required.
- (4) Quarantine is not required.
- (5) Protection/immunization of contacts is not available.

Sec. 72. Hepatitis A. The specific control measures for hepatitis, viral, Type A (infectious agent: Hepatitis A virus) are as follows:

- (1) An investigation shall be performed by the local health officer immediately to determine whether the case is a food handler, day care or health care worker, or day care attendee, and worked or attended while having diarrhea. Investigator shall prepare a list of all contacts. Contacts are defined as household members, day care center attendees in same room, sexual partners, and persons eating food prepared by the case during the infectious period. The infectious period is defined as from seven (7) days before to fourteen (14) days after onset of symptoms if no jaundice occurred; otherwise, the infectious period is defined as from fourteen (14) days prior to seven (7) days after the onset of jaundice. The investigation shall also include a food history, history of exposure to undercooked food items, and a history of sexual exposure during the fifteen (15) to fifty (50) day period prior to onset of illness. In the event that a common source foodborne outbreak is suspected, the local health officer must initiate active surveillance immediately to identify additional cases.

- (2) Contact precautions as follows:

- (A) For diapered or incontinent patients less than three (3) years of age for the duration of the illness.
- (B) In children three (3) to fourteen (14) years of age, until two (2) weeks after the onset of the symptoms.
- (C) In others for two (2) weeks after the onset of the symptoms or one (1) week after the onset of jaundice

Infected children shall be excluded from schools and day care centers, and adults from

employment involving food handling, direct care of children, or hospitalized or institutionalized patients during the infectious period.

(3) Sanitary disposal of feces, vomitus, and blood is required. Disposal through the sanitary system is acceptable.

(4) Quarantine is not required.

(5) Passive immunization with immune globulin (IG) should be given as soon as possible after exposure, but within two (2) weeks to all household and sexual contacts. In a day care center, IG should be given to all classroom contacts. If the day care center admits children in diapers, IG should be given to all children and staff in the center. If a food handler is diagnosed with hepatitis A, IG should be administered to other food handlers (unless the employee is immune due to vaccination or past infection) at the same location. Any susceptible food handler who refuses IG prophylaxis is to be restricted from working with exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles for fifty (50) days. IG should not routinely be given to contacts in the usual office, school, or factory situation. When hepatitis A occurs in a food handler, IG shall be considered for food establishment patrons in the establishment only if the following three (3) events occurred:

(A) The food handler worked while infectious, and directly handled uncooked foods or foods after cooking.

(B) Deficiencies in personal hygiene are noted, or the food handler worked while ill with diarrhea.

(C) IG may be given within two (2) weeks after the last exposure.

Sec. 73. Hepatitis B. The specific control measures for hepatitis, viral, Type B (infectious agent: Hepatitis B virus) and Type D (infectious agent: Delta Hepatitis, occurs only in individuals with acute or chronic hepatitis B virus infection) are as follows:

(1) An investigation and case management duties are assigned as follows:

(A) An Investigation and case management of infants born to HBsAg (+) pregnant women shall begin immediately (when infection is identified at or close to the time of birth) and shall be performed by trained department immunization representatives in cooperation with the local health officer or trained local health department staff for the purpose of assuring that infants receive the complete HBIG and HBV vaccine series.

(B) The local health officer shall perform investigation and case management of all others, including household and sexual contacts of HBsAg (+) pregnant women. Investigators shall identify a complete list of contacts. Contacts are defined as sexual partners, household members, individuals with whom needles have been shared, and others who have been exposed to infectious body fluids. In addition, the investigation shall focus on history of surgery, transfusion or other blood product exposures, hemodialysis, employment as a health care worker, and other contacts with blood or other potentially infectious materials during the incubation period. When two (2) or more cases occur in association with some common exposure, a search for additional cases shall be conducted. If transfused blood or blood products is implicated in transmission, the lot shall be withdrawn from use and reasonable steps taken to ensure that no further donations from the infected donor are utilized.

(C) Hepatitis B immunization history shall be obtained on all cases of hepatitis B.

(2) Standard precautions for hospitalized patients and universal precautions for others where

exposure to blood or other potentially infectious materials or both is a possibility. Infected persons shall not engage in sexual activities involving the exchange of body fluids without first informing their partner of their disease status. Restrictions on sexual activities shall be removed when the previously infected person is serologically confirmed to be noninfectious. The infected persons shall not:

- (A) share needles or syringes with other persons without first notifying those persons of their disease status;
 - (B) donate blood, plasma, or organs for transplantation; or
 - (C) donate semen for artificial insemination.
- (3) Equipment contaminated with blood or other potentially infectious body fluids or both shall be appropriately disinfected or when required, sterilized prior to reuse.
- (4) Quarantine is not required.
- (5) Protection/immunization of contacts shall be accomplished as follows:
- (A) Infants of HBsAg(+) pregnant women shall be given the appropriate dosage of HBIG IM and of hepatitis B vaccine within twelve (12) hours of birth unless medically contraindicated. Additional doses of vaccine should be given at one (1) month and six (6) months of age. Infants should be tested for anti-HBs and HBsAg one (1) to three (3) months after completing the vaccine series.
 - (B) Potentially susceptible sexual partners should be tested for HBsAG, HBsAB, and anti-HBc; if negative, they should be given the appropriate dosage of HBIG IM and the first dose of hepatitis B vaccine IM within fourteen (14) days of the last sexual contact. Sexual contacts should complete the hepatitis B immunization series.
 - (C) If the index case is the mother or primary care provider of a susceptible infant less than twelve (12) months of age, the infant should receive the appropriate dosage of HBIG and hepatitis B vaccine according to vaccine manufacturer's directions.
 - (D) Other susceptible household contacts of the index case should receive the appropriate dosage of HBIG IM and initiate and complete hepatitis B vaccine if they have had identifiable blood exposures to the index case, such as sharing toothbrushes or razors.
 - (E) If the index case becomes a hepatitis B carrier, all household contacts should complete the hepatitis B vaccine series.

Sec. 74. Hepatitis C. The specific control measure for hepatitis C (acute) are as follows:

- (1) An investigation shall be performed within seventy-two (72) hours by the local health officer for the purpose of determining risk factors for infection.
- (2) Standard for hospitalized patients and universal precautions for others, where exposure to blood or other potentially infectious materials or both is a possibility. Infected persons shall not:
 - (A) share needles or syringes with other persons;
 - (B) donate blood, plasma, or organs for transplantation; or
 - (C) donate semen for artificial insemination.
- (3) Equipment contaminated with blood or other infectious body materials or both, shall be appropriately disinfected or sterilized prior to reuse.
- (4) Quarantine is not required.
- (5) HCV-positive individuals shall not share razors or toothbrushes with others. Infants twelve

(12) months of age or older born to infected mothers should be screened for anti-HCV. Health care workers with percutaneous or permucosal exposure to HCV shall have baseline and six (6) month follow-up serologic testing for anti-HCV and alanine aminotransferase activity.

Sec. 75. Histoplasmosis. The specific control measure for histoplasmosis (infectious agent: *Histoplasma capsulatum*) are as follows:

- (1) A local health officer shall investigate cases of infection to potential sources of exposure. The investigation shall evaluate the potential for occupational exposure, and in the event of two (2) or more cases for evidence of infection from a common environmental source.
- (2) Standard precautions for hospitalized patients shall be instituted. No isolation is required for others.
- (3) Concurrent disinfection is required for sputum and equipment and articles soiled with sputum. Terminal cleaning is also required.
- (4) Quarantine is not required.
- (5) Protection/immunization of contacts is not available.

Sec. 76. HIV. The specific control measures for HIV are as follows:

- (1) An investigation shall be performed by trained public health disease intervention specialists who shall conduct any contact tracing. Persons who are tested anonymously at a counseling and testing sites cannot be reported using personal identifiers; rather, they are to be reported using a numeric identifier code. Age, race, sex, risk factors, and county of residence shall also be reported. HIV infected persons are required to warn contacts of their disease status and the need to seek health care, such as counseling and testing. All identified contacts should receive counseling and be offered serologic testing. Until their status with regard to infection has been determined, contacts shall refrain from sexual activities involving the exchange of body fluids. All contacts shall not share needles and syringes with other persons without first notifying the other persons of their disease status.
- (2) Standard precautions shall be used in hospitalized patients. Universal precautions shall be used for all other medical settings. Infected persons shall not:
 - (A) engage in sexual activities involving exchange of body fluids without first informing their partner of their disease status;
 - (B) share needles or syringes with other persons without first notifying the other persons of their disease status; or
 - (C) donate blood, plasma, organs for transplantation, or semen for artificial insemination.
- (3) Concurrent disinfection is required for equipment and articles contaminated by blood or other potentially infectious material.
- (4) Quarantine is not required.
- (5) An investigation of HIV positive women, perinatally exposed infant and pediatric HIV cases will be performed by HIV surveillance and disease intervention specialist staff members, who will obtain information epidemiologically necessary to protect the life of named parties.

Sec. 77. Legionellosis. The specific control measures for legionellosis (infectious agent: *Legionella* species) are as follows:

- (1) An investigation shall be performed by the local health officer in the event that a single

nosocomial case is identified or in the event that two (2) or more cases not associated with a health care facility are identified. A definite nosocomial case is a laboratory confirmed case who has spent ten (10) days or more continuously in a health care facility. A possible nosocomial case is a laboratory case that occurs two (2) to nine (9) days after discharge from a health care facility. The investigation shall focus on environmental sources for the exposure in the health care facility for nosocomial cases, or places of common exposure for those infections not associated with a health care facility. Active surveillance for additional cases shall be undertaken.

(2) Standard precautions for hospitalized patients is required.

(3) Equipment contaminated with blood or infectious body fluids or both shall be appropriately disinfected or sterilized prior to reuse.

(4) Quarantine is not required.

(5) Protection/immunization of contacts is not available.

Sec. 78. Leptospirosis. The specific control measure for leptospirosis (infectious agent: *Leptospira* species) are as follows:

(1) An investigation by the local health officer shall be conducted for case ascertainment and to identify potential sources of the infection, such as contaminated water, occupational exposure, including handling of infected animals.

(2) Standard precautions are required.

(3) Quarantine is not required.

(4) Protection for contacts is not required.

Sec. 79. Listeriosis. The specific control measure for listeriosis (infectious agent: *Listeria monocytogenes*) are as follows:

(1) An investigation by the local health officer shall include a twenty-one (21) day food history, exposure to soil, and farm animals. Food history should include history of consuming raw milk, soft cheese, raw vegetables, and ready-to-eat meats. Surveillance data should be analyzed for clusters, and clusters for common source exposures.

(2) Standard precautions for hospitalized patients are required.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required.

(5) Protection/immunization of contacts is not required.

Sec. 80. Lyme Disease. The specific control methods for lyme disease (infectious agent: *Borrelia burgdorferi*) are as follows:

(1) The local health officer shall investigate to determine location of exposure to ticks and identify tick-infested areas.

(2) Standard precautions for hospitalized patients are required.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required.

(5) Protection/immunization of contacts is not required.

Sec. 81. Lymphogranuloma Venereum. The specific control measures for lymphogranuloma venereum (infectious agent: *Chlamydia trachomatis*) are as follows:

- (1) Contact tracing shall be conducted by a trained public health disease control specialist.
- (2) Standard precautions for hospitalized patients are required. Refrain from sexual contact until lesions are healed.
- (3) Careful disposal of articles contaminated with discharges from lesions and articles soiled by discharges is required.
- (4) Quarantine is not required.
- (5) Protection/immunization of contacts is not available. Sexual contacts of patients with *C. trachomatis* infections should be evaluated and treated for *C. trachomatis* if the last sexual contact was within thirty (30) days of a symptomatic index patient's onset of symptoms, or within sixty (60) days of an asymptomatic index patient's diagnosis. Cases should also be examined serologically for syphilis initially.

Sec. 82. Malaria. The specific control measures for malaria (infectious agents: *Plasmodium vivax*, *P. malariae*, *P. falciparum*, and *P. ovale*) are as follows:

- (1) An investigation by the local health officer to determine history of previous infection or possible exposure. Travel history shall be evaluated to determine if the case is from foreign travel or local exposure. Exposure may occur from exposure to infected mosquitoes, transfusions with infected blood, or through needle sharing.
- (2) Standard precautions for hospitalized patients are required. Both hospitalized and nonhospitalized patients shall remain in mosquito-proof areas from dusk to dawn.
- (3) Concurrent disinfection is not required.
- (4) Quarantine is not required.
- (5) Protection/immunization of contacts is not applicable.

Sec. 83. Rubeola. The specific control measures for measles (rubeola) are as follows:

- (1) An investigation and case management shall be performed immediately by department trained immunization field representatives in cooperation with the local health officer. The investigation shall consist of the following:
 - (A) Ascertainment of immunization history.
 - (B) Case ascertainment.
 - (C) Identification and listing of contacts. Contacts are defined as any individual who was in the same room while the case was present, or for two (2) hours afterwards at any time during the infectious period. The infectious period is defined as four (4) days before rash onset until four (4) days after the appearance of the rash. All children and adults attending the same school, child care, or babysitting groups as the case are defined as contacts.
 - (D) For outbreak control in public or private schools, on the same day that a report of a suspected case of measles is received, school personnel shall do the following:
 - (i) Conduct an inquiry into absenteeism to determine the existence of any other cases of the illness.
 - (ii) Immediately report the suspect case or cases to the local health department or the department.
 - (iii) Send a notice home with each student or attendee who has not presented proof of

immunity explaining that the student shall be excluded from a given date, until acceptable proof of immunity is received by the school, or in the case of medical or religious exemptions, until fourteen (14) days after the onset of the last reported measles case. Previously unvaccinated children who are not vaccinated within seventy-two (72) hours of exposure shall also be excluded for fourteen (14) days after completing vaccination. Acceptable proof shall consist of:

(AA) a written record from the student's physician, parent, or guardian, which indicates the dates of vaccination (on or after the first birthday) and the type of vaccine administered;

(BB) a statement from a physician indicating the date when a student had measles; or

(CC) a laboratory report showing a protective measles antibody titer.

(iv) Make available to officials of the local health department or the department, or both, involved in investigating and controlling the outbreak, immunization records of all students in the school or attendees in child care.

(2) Airborne precautions shall be followed for hospitalized patients from onset of the catarrhal stage of the prodromal period through the fourth day of the rash to reduce the exposure of other persons at high risk. Other infected persons shall be excluded from school and day care centers, from public gatherings, and from contact with susceptible persons outside the household for at least four (4) days after appearance of the rash.

(3) Concurrent disinfection is not required.

(4) Quarantine is not required. Children in institutions, wards, or dormitories for young children may be quarantined. If measles occurs in an institution where infants reside, these infants shall be segregated from infected persons and susceptible contacts.

(5) Protection/immunization of contacts shall be as follows:

(A) Live measles vaccine given to inadequately vaccinated persons within seventy-two (72) hours of exposure may provide protection against disease.

(B) Immune globulin (IG) may be given within six (6) days to the susceptible household or other contacts, especially those for whom risk of complications is very high (such as contacts under one (1) year of age), or for whom the measles vaccine is contraindicated.

(C) Live measles vaccine should be given three (3) months later to IG recipients for whom vaccine is not contraindicated.

Sec. 84. Meningitis. The specific control measures for aseptic meningitis (infectious agent: various viral agents) is an investigation by the local health officer that shall be conducted when reports exceed the expected number for population in time period. The investigation shall be focused on determining cause of the disease and its distribution.

Sec. 85. Meningococcal Disease. The specific control measures for meningococcal disease, invasive (infectious agent: *Neisseria meningitidis*) are as follows:

(1) An investigation shall be performed immediately by the local health officer for the purpose of identifying all close contacts. Contacts are defined as household contacts, day care contacts, and anyone directly exposed to the patient's oral secretions. Investigation shall also be performed to identify school attendance and work history of the case, or history of habitual association with an agency, organization, or institution.

- (2) Droplet precautions are required for hospitalized patients until twenty-four (24) hours of effective antimicrobial therapy has been completed.
- (3) Concurrent disinfection are required for discharges from nose and throat, and all articles soiled by them. Terminal cleaning is required.
- (4) Quarantine is not required.
- (4) Protection/immunization of contacts should be treated as follows:

Rifampin		
Children \leq 1 month of age		5 mg/kg orally every 12 hours for 2 days
Children $>$ 1 month of age and adults		10 mg/kg (maximum 600 mg) orally every 12 hours for 2 days or 20 mg/kg (maximum 600 mg) orally every 24 hours for 4 days
Ceftriaxone		
	\leq 12 years of age	125 mg intra muscular (I.M.) single dose
	$>$ 12 years of age	250 mg intra muscular (I.M.) single dose
Ciprofloxacin		
	\geq 18 years of age	500 mg orally single dose

Sec. 86. Mumps. The specific control measures for mumps are as follows:

- (1) An investigation shall be conducted by trained department immunization field representatives in cooperation with the local health officer. The investigation shall include obtaining serology for mumps IgM in suspect cases, and identifying susceptible contacts who should be immunized.
- (2) For hospitalized patients, droplet precautions are indicated for nine (9) days from the onset of swelling.
- (3) Concurrent disinfection shall be followed to disinfect articles contaminated with nose and throat secretions.
- (4) Infected persons shall be excluded from school and day care centers, public gatherings, and contact with susceptible persons outside the household for nine (9) days after the onset of swelling. Exclude exposed susceptibles from school or the workplace from the twelfth to the twenty-fifth days after exposure to prevent spread to other susceptibles.
- (5) Vaccination of susceptibles after exposure to mumps may not prevent disease; however, vaccination may be given to protect against subsequent exposures.

Sec. 87. Pediatric Blood Lead. The specific control measures for pediatric venous blood lead are as follows:

- (1) Local health officers shall ensure the monitoring of children, equal to or less than six (6) years of age, who have been reported to have a venous blood lead level of greater than 10 µg per deciliter. Monitoring shall include referrals for case management if not already accomplished and environmental assessment. Additional guidance may be found in Center for Disease Control and Prevention publication Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials, November 1997.
- (2) Ensure that additional testing is accomplished in accordance with the following schedule:
 - (A) Initial blood level 10-19 µg per deciliter, rescreen within three (3) months.
 - (B) Initial blood level 20-44 µg per deciliter, rescreen within one (1) month.
 - (C) Initial blood level 45-59 µg per deciliter, rescreen within forty-eight (48) hours.
 - (D) Initial blood level 60-69 µg per deciliter, rescreen within twenty-four (24) hours.
 - (E) Initial blood level equal to or greater than 70 µg per deciliter, rescreen immediately as an emergency lab test.

Sec. 88. Pertussis. The specific control measures for pertussis (infectious agent: *Bordetella pertussis*) are as follows:

- (1) Immediate investigation shall be performed by trained department immunization field representatives in cooperation with the local health officer. An investigation shall be performed for the purpose of case ascertainment and identification of close contacts. Close contacts are defined as household and day care contacts and persons who have had direct contact with respiratory secretions of the case, including, but not limited to, the following:
 - (A) Explosive cough or sneeze in the face.
 - (B) Sharing food or utensils.
 - (C) Kissing.
 - (D) Mouth to mouth resuscitation.
 - (E) Performing a full medical exam, including examination of the nose and throat.

A search for unrecognized or unreported, early, and atypical cases is indicated where a nonimmune infant or young child is, or might be, at risk.

- (2) Droplet precautions shall be utilized for hospitalized patients for five (5) days after the start of effective therapy. For others, inadequately immunized household contacts less than seven (7) years of age shall be excluded from schools, day care centers, and public gatherings for fourteen (14) days after the last exposure, or until they have received five (5) days of a minimum fourteen (14) day course of erythromycin or trimethoprim-sulfamethoxazole. Infected persons shall be excluded from:

- (A) schools and day care centers;
- (B) public gatherings; and
- (C) contact with susceptible persons outside the household;

until they have received at least five (5) days of a minimum fourteen (14) day course of erythromycin or trimethoprim-sulfamethoxazole. Infected persons shall not have contact with unimmunized infants. Infected persons not receiving the prophylaxis as established in this subdivision shall be excluded from schools, day care centers, and public gatherings for twenty-one (21) days.

- (3) Concurrent disinfection is required for nose and throat discharges, and any articles soiled by nose and throat discharges.
- (4) For quarantine, see subdivision (1) for inadequately immunized contacts.
- (5) Close contacts less than seven (7) years of age who have not received four (4) diphtheria, tetanus, or pertussis (DTP or DTaP) doses, or have not received a DTP dose within three (3) years should be given a DTaP dose as soon after exposure as possible. A fourteen (14) day course of erythromycin (forty (40) to fifty (50) milligram per kilogram per day (mg/kg/day), orally in four (4) divided doses, maximum two (2) grams per day (gm/day)) for all household and other close contacts regardless of age and vaccination status should be given. While efficacies have not been established, clarithromycin, other macrolides, or trimethoprim-sulfamethoxazole are alternatives for those who cannot tolerate erythromycin. Those with symptoms should be cultured before antibiotic therapy. Immunization after discovery of a case or an outbreak does not provide protection to newly immunized persons during that outbreak; therefore, contacts must be protected immediately by other measures.

Sec. 89. Plague. The specific control measures for plague (infectious agent: *Yersinia pestis*) are as follows:

- (1) The local health officer shall perform an immediate investigation to identify all contacts. Contacts are defined as those individuals who have been in household or face to face contact with patients with pneumonic plague. Establish if the case had traveled to endemic areas in the past seven (7) days. Determine if patients were exposed to rodents, or cats, or dogs, or visited areas of rodent habitat during travel.
- (2) Standard precautions are required for hospitalized patients with bubonic plague. Droplet precautions for hospitalized patients with pneumonic plague are required until seventy-two (72) hours after the start of effective therapy.
- (3) Concurrent disinfection is required for sputum and purulent discharges, and articles soiled with them.
- (4) Those who have had face-to-face contact or are in a household with patients shall be placed on chemoprophylaxis and observed for seven (7) days. Those who refuse chemoprophylaxis must be isolated for seven (7) days.
- (5) Close contacts (including medical personnel) shall be evaluated for chemoprophylaxis. Contacts of pneumonic plague shall be provided chemoprophylaxis. Children less than eight (8) years of age should be given trimethoprim-sulfamethoxazole. For children older than eight (8) years of age and adults, doxycycline or tetracycline is recommended.
- (6) Streptomycin and gentamycin are drugs of choice in most cases. Tetracyclines and chloramphenicol are alternatives.

Sec. 90. Poliomyelitis. The specific control measures for poliomyelitis are as follows:

- (1) Immediate investigation shall be performed by a trained department immunization field representative in cooperation with the local health officer. The investigation shall include the following:
 - (A) Laboratory confirmation.
 - (B) Immunization status of the case.

(C) Time since the last vaccination.

(D) Type of vaccine given.

(E) History of underlying immunosuppressive condition.

(F) History of contact with high risk individuals (such as persons who object to vaccination, recent immigrants, travelers, and persons who are a probable or confirmed case of polio).

Travel history of the case shall be determined. If wild poliovirus is implicated and at least two (2) cases are associated by time and place, an immunization program designed to contain the spread shall be initiated using trivalent oral polio vaccine. A thorough search shall be conducted for sick persons, especially children, to assure early detection, facilitate control, and permit appropriate treatment of unrecognized and unreported cases.

(2) For hospitalized patients, standard precautions are required. Other infected persons shall be excluded from schools and day care centers, public gatherings, and contact with susceptible persons outside the home for a period of not less than fourteen (14) days after the onset of illness.

(3) Concurrent disinfection shall be followed for throat discharges, feces, and articles soiled by throat discharges or feces, or both. Feces may be disposed of directly into sanitary sewage system. Terminal cleaning shall also be followed.

(4) Familial and other close contacts may be vaccinated, but this measure, when implemented after recognition of the case, is of unknown value.

Sec. 91. Psittacosis. The specific control measures for psittacosis (infectious agent: *Chlamydia psittaci*) are as follows:

(1) An investigation by the local health officer shall be instituted to identify the source of infection and implementation of control measures. The investigation shall identify exposure to:

(A) psittacine birds (owned by individuals, or pet shops);

(B) occupational exposure to poultry flocks; or

(C) processing plants;

for the previous four (4) weeks. Identified locations for potential exposure shall be forwarded to the Indiana state board of animal health for investigation.

(2) Standard precautions are required. Coughing patients shall cough into tissue to prevent aerosolization of infectious agent.

Sec. 92. Q Fever. The specific control measure for Q fever (infectious agent: *Coxiella burnetii*) are as follows:

(1) An investigation shall be conducted by the local health officer for case ascertainment and identification of an infection source.

(2) Standard precautions for hospitalized patients shall be taken.

(3) Quarantine is not required.

(4) Investigation for the infection source shall be directed at exposure to sheep, cattle, goats, laboratories that handle the agents, and consumption of unpasteurized milk.

Sec. 93. Rabies. The specific control measures for rabies (see animal bites also) are as follows:

- (1) An investigation shall be accomplished by the department veterinary epidemiologist in collaboration with the local health officer. The investigation shall identify the route of exposure, the animal responsible for exposure, and other individuals who may have been exposed to that animal or to the salivary secretions of the patient. Individuals who have been exposed to salivary secretions of the patient shall be evaluated for postexposure prophylaxis (postexposure prophylaxis guidance is provided in section 52 of this rule).
- (2) Standard precautions shall be followed for hospitalized patients. Health care workers shall prevent mucous membrane and open wound contact with patient's saliva.
- (3) Concurrent disinfection is required. Saliva and articles contaminated with saliva shall be disinfected.
- (4) Contacts who have experienced saliva exposure to open wounds or mucous membranes should receive postexposure prophylaxis.

Sec. 94. Rocky Mountain Spotted Fever. The specific control measures for Rocky mountain spotted fever (infectious agent: *Rickettsia rickettsii*) are as follows:

- (1) The local health officer shall investigate to determine location of exposure to infected ticks. Recent travel, as well as exposure to tick infected areas, shall be identified.
- (2) Standard precautions are required for hospitalized patients.
- (3) Carefully remove all ticks from the patient to avoid contact with infectious agent.
- (4) Quarantine not necessary.
- (5) Immunizations for contacts are not available.

Sec. 95. Rubella. The specific control measures for rubella (German measles) are as follows:

(1) An investigation and case management shall be performed immediately by a trained department immunization field representative with the cooperation of the local health officer. The investigation shall include case ascertainment, previous immunization history, and identification of exposed pregnant female and other susceptible contacts. For outbreak control in public or private schools or child care facilities, on the same day that a report of a suspected case of rubella is received, school personnel shall do the following:

- (A) Conduct an inquiry into absenteeism to determine the existence of any other cases of the illness.
- (B) Immediately report the suspect case or cases to the local health department or the department.
- (C) Send a notice home with each student or attendee who has not presented proof of immunity, explaining that the student shall be excluded from a given day, until acceptable proof of immunity is received by the school, or in the case of medical or religious exemptions, until twenty-three (23) days after the onset of the last reported rubella case. Acceptable proof shall consist of the following:
 - (i) A written record from the student's physician or parent or guardian that indicates the dates of vaccination (on or after the first birthday) and the type of vaccine administered.
 - (ii) A laboratory report showing a protective rubella antibody titer.

- (D) Make available to officials of the local health department or the department, or both, involved in investigating and controlling the outbreak, immunization records of all students in the school, or attendees in child care.
- (2) Droplet precautions shall be followed for seven (7) days after onset of a rash. Contact precautions shall be followed for suspected or known congenital rubella until one (1) year of age unless urine and nasopharyngeal cultures are negative for the virus after three (3) months. In hospitals and institutions, patients suspected of having rubella shall be managed in a private room. Infected persons shall be excluded from:
- (A) schools and day care centers;
 - (B) places of work;
 - (C) public gatherings; and
 - (D) contact with susceptibles outside the household;
- for seven (7) days after onset of a rash.
- (3) Immunization, while not contraindicated (except during pregnancy), will not necessarily prevent infection or illness. Passive immunization with immune globulin may be given to a susceptible pregnant woman exposed to the disease, but should only be administered after thorough consultation with her attending physician, and any such measure should be provided by her attending physician. Pregnant female contacts, especially those in the first trimester, should be referred immediately to their attending physician for serological testing to determine susceptibility or early infection (IgM) antibody and for thorough medical consultation.

Sec. 96. *Salmonella.* The specific control measures for salmonellosis, other than typhoid fever, (infectious agent: *Salmonella* species) are as follows:

- (1) An investigation by the local health officer shall be accomplished immediately to determine if the affected individual is a food handler, day care attendant or attendee, or health care worker. Further investigation shall be performed to determine a three (3) day food consumption history with emphasis on exposure to inadequately cooked poultry and poultry products, uncooked or lightly cooked eggs or egg products, raw milk, and dairy products. Interview meal companions to identify additional cases and if a commercial food product or restaurant is suspected, conduct active surveillance for additional cases. Medical evaluation, including adequate laboratory examination of feces of contacts should be limited to food handlers, child care attendants, health care workers, or other situations where outbreaks may occur.
- (2) Contact precautions shall be followed for diapered or incontinent patients less than six (6) years of age for the duration of the illness, and standard precautions shall be followed for other hospitalized patients. For other individuals, the following guidelines shall be followed:
- (A) Symptomatic persons shall be excluded from employment involving food handling, direct care of children, or hospitalized or institutionalized patients.
 - (B) Asymptomatic day care workers and health care workers may return to work, providing they have met the requirement of clauses (C) and (D) prior to that person's return to work. Once clauses (C) and (D) are met, asymptomatic food handlers may return to work, but will be restricted from working with:
 - (i) exposed food;
 - (ii) clean equipment, utensils, and linens; and
 - (iii) unwrapped single-service and single-use articles;

until they are determined to be free of *salmonella* as described in clause (E).

(C) The local health officer discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic, and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.

(D) The local health officer contacts the employer to reemphasize the need to:

(i) comply with local and state rules requiring proper hand washing facilities for all employees; and

(ii) correct any observed lapses in hygiene measures of any employees.

(E) The worker has had two (2) successive negative fecal samples or rectal swabs (collected greater than twenty-four (24) hours apart) and no sooner than forty-eight (48) hours after cessation of any antibiotic therapy.

(F) Symptomatic individuals shall be excluded from schools and day care centers. Once determined to be asymptomatic, excluded individuals may be readmitted to schools and day care centers.

(G) If an outbreak of the infection occurs in a day care center, all attendees may be required to submit stool specimens for examination. In addition, the local health officer may order asymptomatic attendees and staff who are infected with *Salmonella* organisms to be isolated from other attendees and staff in the same center, and admission of all new attendees suspended while the outbreak continues.

(3) Concurrent disinfection is required for feces and fecal contaminated articles. Feces may be disposed directly into a sanitary sewage system. Terminal cleaning is required.

Sec. 97. *Shigella*. The specific control measures for shigellosis (infectious agent: *Shigella* species) are as follows:

(1) An investigation shall be performed immediately by the local health officer to determine whether the case is a food handler, day care worker, health care worker, day care attendee, or attendee at other institutions. Further investigation shall be performed to determine a seven (7) day food consumption and water source history. The investigation shall identify household members and contacts who are food handlers, health care or day care workers, or those who care for elderly people in institutional settings. Any such contacts shall have stools cultured, whether asymptomatic or not, to identify other infected individuals.

(2) Contact precautions are required for diapered or incontinent patients less than six (6) years of age for the duration of the illness, and standard precautions for other hospitalized patients. For others, the following steps shall be taken:

(A) Patients with known *Shigella* infections, shall be excluded from employment involving food handling, direct care of children, or hospitalized or institutionalized patients until two (2) successive fecal specimens collected more than twenty-four (24) hours apart, and not less than forty-eight (48) hours after completion of antimicrobial therapy, have been determined to be culture negative for *Shigella* organisms. Infected children shall be excluded from day care centers until asymptomatic and have completed five (5) days of specific antimicrobial therapy or if antibiotics are not administered until two (2) successive fecal specimens collected not less than twenty-four (24) hours apart have been determined to be negative for *Shigella* organisms.

(B) Symptomatic school children shall be excluded from schools, but may be allowed to return after:

- (i) symptoms cease;
- (ii) appropriate antimicrobial therapy has been initiated for at least forty-eight (48) hours; and
- (iii) education regarding good hygiene has been provided to the case.

If an outbreak occurs in a school, the administrator may exclude symptomatic students and staff until two (2) successive fecal specimens collected not less than twenty-four (24) hours apart, and at least forty-eight (48) hours after cessation of specific therapy have been determined to be negative for *Shigella* organisms. If an outbreak occurs in a day care center, all attendees and staff may be required to submit stool specimens for examination. Symptomatic children shall be excluded until asymptomatic, and completion of five (5) days of specific antimicrobial therapy. The day care administrator may consider isolation of infected but asymptomatic attendees from other attendees instead of exclusion until stool negative or five (5) days of specific antimicrobial therapy. This alternative can only be considered if the physical structure and staff organization of the center can accommodate isolation of various attendee groups from one another.

(3) Concurrent disinfection is required for feces and fecal contaminated articles. Feces may be disposed of directly in sanitary sewage system.

(4) There is no immunization available.

Sec. 98. *Staphylococcus Aureus.* The specific control measures for *Staphylococcus aureus*, vancomycin resistant level ≥ 8 ug/mL, are as follows:

(1) An investigation by the department in collaboration with the local health officer shall be accomplished within seventy-two (72) hours to verify resistant or intermediate resistant culture isolate to vancomycin. The investigation includes laboratory verification of resistance. Abrupt increases in the prevalence of the disease in the community shall be investigated for a common source.

(2) For hospitalized patients, contact precautions are required..

(3) Concurrent disinfection is required for all discharges from the skin, wound, or burn and articles contaminated with discharges. Fecal material may be disposed of in a sanitary sewer.

Sec. 99. *Streptococcus Pneumoniae.* The specific control measures for invasive *Streptococcus pneumoniae* are as follows:

(1) An investigation of contacts and the source of infection shall be as follows:

(A) An investigation by a department-trained immunization field representative in collaboration with the local health officer for cases less than or equal to five (5) years of age within seventy-two (72) hours. The investigation shall include complete pneumococcal vaccine immunization history, history of antibiotic use, history of chronic underlying disease, asplenia or immunosuppression, and drug resistance pattern of isolate.

(B) An investigation by a local health officer for all other cases shall be performed within seventy-two (72) hours. The investigation shall include complete pneumococcal vaccine immunization history, history of chronic underlying disease, asplenia or immunosuppression, and drug resistance pattern of isolate.

(2) For hospitalized patients, standard precautions are required.

- (3) Disinfect purulent discharges and articles soiled by them.
- (4) Protection/immunization of contacts is not required.

Sec. 100. Invasive Streptococcal and Toxic Shock Syndrome. The specific control measures for invasive streptococcal infections and toxic shock syndrome (infectious agent: *Streptococcus pyogenes*) are as follows:

- (1) An investigation within seventy-two (72) hours by the local health officer to ascertain that the case meets the case definition for invasive Group A streptococcal or streptococcal toxic shock syndrome. Identify if the case had a recent case of varicella or underlying chronic disease. Be alert for outbreaks defined as two (2) or more cases occurring close together in place and time.
- (2) For hospitalized young children with pharyngitis, pneumonia, or scarlet fever, droplet precautions shall be followed until at least twenty-four (24) hours of antimicrobial therapy have been administered. For patients with skin, wound, or burn infections, contact precautions shall be followed for at least twenty-four (24) hours after antimicrobial therapy has been administered.
- (3) Discharges and articles soiled with discharges shall be disinfected.
- (4) Immunization is not available.

Sec. 101. Group B *Streptococcus*. The specific control measures for invasive Group B *streptococcus* are as follows:

- (1) An investigation within seventy-two (72) hours by the local health officer to ascertain that the case meets the case definition (infection of a normal sterile site, that is, blood, or CSF) and to identify outbreaks, defined as two (2) or more cases occurring close together in place and time.
- (2) For hospitalized patients, standard precautions are required.
- (3) Disinfection of discharges and articles contaminated by discharges shall be done.

Sec. 102. Syphilis. The specific control measures for syphilis (infectious agent: *Treponema pallidum*) are as follows:

- (1) An investigation shall be accomplished by trained public health disease control specialists in cooperation with the local health officer. The investigation shall be focused on identifying sexual partners who were at risk for transmitting to or contacting the infection from the case. Cases and contacts shall be fully evaluated (including pregnancy status of females) and treated as recommended in the MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1.
- (2) For hospitalized patients standard precautions are required. For others, the infected persons shall refrain from sexual activities involving exchange of body fluids until their lesions clear and they have been on appropriate antibiotic therapy for at least twenty-four (24) hours. Treated persons shall also avoid sexual activities involving exchange of body fluids with untreated partners to avoid reinfection.
- (3) Disinfection is not required in adequately treated cases, but care shall be taken to avoid contact with discharges from open lesions and articles soiled by discharges.
- (4) Quarantine is not required.

(5) Immunization is not available.

Sec. 103. Tetanus. The specific control measures for tetanus (infectious agent: *Clostridium tetani*) are as follows:

- (1) An investigation shall be accomplished within seventy-two (72) hours by a department-trained immunization field representative with the cooperation of the local health officer.
- (2) The investigation shall include:
 - (A) a complete tetanus toxoid immunization history;
 - (B) circumstance of injury; or
 - (C) possible source of infection.

Sec. 104. Toxic Shock Syndrome. The specific control measures for toxic shock syndrome (Staphylococcal) are as follows:

- (1) An investigation by the local health officer shall be accomplished within seventy-two (72) hours for case ascertainment, clinical findings, culture results, and suspected source of infection.
- (2) Standard precautions shall be followed.
- (3) Sanitary disposal of blood and articles soiled with body discharges.

Sec. 105. Trichinosis. The specific control measures for trichinosis (infectious agent: *Trichinella spiralis*) are as follows:

- (1) An investigation by the local health officer shall be accomplished within seventy-two (72) hours. Collect food consumption history, concentrating on meats, for eight (8) to forty-five (45) days prior to the onset of symptoms. Travel history may provide leads to unusual foods or source of foods with increased risk. Identify and interview family members and others that the case normally shares meals with to identify additional cases.
- (2) Standard precautions are required.

Sec. 106. Tuberculosis. The specific control measures for tuberculosis (infectious agent: *Mycobacterium tuberculosis*) are as follows:

- (1) An investigation and case management are the responsibility of the local health officer and shall begin immediately. The local health officer shall request laboratory, radiological, and other studies as required for case ascertainment and to determine if the suspect case should be isolated as described in subdivision (5)(B). For confirmed and suspected cases of *tuberculosis*, a contact investigation shall be performed, identifying both household and close contacts. As used in this subdivision, "close contact" means an individual who has shared breathing air space with a tuberculosis case for prolonged periods of time in circumstance or frequency that would allow airborne transmission. Examples of close contacts are household members, co-workers, and friends. If several of the close contacts are PPD positive, then contact investigation shall be expanded to include persons who have been progressively in less contact with source or suspect.
- (2) Pulmonary tuberculosis cases and suspects who are sputum-smear negative, are clinically improving, and are known to be on adequate tuberculosis chemotherapy are defined as noninfectious. All other pulmonary tuberculosis cases and suspects must be isolated until no

longer infectious. In the hospital, tuberculosis cases and suspects must be isolated in accordance with the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings, as published by Centers for Disease Control and Prevention in Morbidity and Mortality Weekly Report, October 28, 1994, Volume 43, No. RR-13. Prior to discharge of cases or suspects, the hospital shall notify the local health department in the jurisdiction where the tuberculosis suspect or case resides. Prior to discharge of the *tuberculosis* case or suspect, the local health department shall make plans, in writing, for continuation of medical follow-up, assuring adherence to therapy and isolation. Plans shall be developed in cooperation with the treating physician and the patient, and must be in accordance with this rule. For patients with confirmed or suspected pulmonary tuberculosis who do not need to be hospitalized, in-home isolation is an acceptable alternative. Contact with persons outside the home shall be prohibited unless the infected person wears a surgical mask, properly tied. Children should not be in the home while the case is considered infectious.

(3) Concurrent disinfection is required and shall include hand washing and good housekeeping practices combined with dilution of particles in the air by ventilation.

(4) Because the potential for unrecognized exposure as well as known exposure of medical personnel to tuberculosis, hospital and laboratories shall develop and follow *tuberculosis* prevention and control programs for their facilities as described in the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings as published by Centers for Disease Control and Prevention in Morbidity and Mortality Weekly Report, October 28, 1994, Volume 43, No. RR-13.

(5) For every case of pulmonary tuberculosis the local health officer must initiate a complete contact investigation within three (3) working days of the report of the case. The first step in performing the contact investigation for pulmonary cases is to estimate the degree of infectiousness and determine the infectious period. Infectiousness is generally predicted by disease in a pulmonary or respiratory (for example, endobronchial or laryngeal site), a lung cavity seen on a chest X-ray, acid fast bacilli (AFB) seen in a smear of concentrated sputum, and protracted cough. Under most circumstances, tuberculosis without a pulmonary or respiratory site is not infectious. The infectious period is defined as the period beginning with onset of symptoms (especially cough) until any of the following endpoints is attained:

(A) Contact is broken with the infectious case.

(B) Effective isolation measures are instituted for that case.

(C) The case is determined to be noninfectious by all of the following criteria:

(i) The index tuberculosis patient has three (3) negative smears for AFB taken twenty-four (24) hours apart.

(ii) Is known to be taking effective antituberculosis chemotherapy.

(iii) Is clinically improving.

The case shall be interviewed in detail to identify all contacts who shared air space during the infectious period. The list of contacts shall then be prioritized according to length and duration of contact with the case, with household contacts, and other close social or workplace contacts given highest priority. High priority shall also be assigned to exposed infants and any exposed persons who have medical conditions, for example, HIV infection, making them vulnerable to tuberculosis.

(6) All household and close contacts not known to have a previously positive tuberculin skin test or active tuberculosis, shall be tested with five (5) TU purified protein derivative (PPD) intradermally by the Mantoux method administered by an individual trained in the administration and reading of tuberculin skin tests. The skin test should be read seventy-two (72) hours later by a trained individual, and the amount of induration in millimeters shall be recorded. If any of the following conditions are met, then the contact investigation shall be progressively expanded to include contacts with lesser degrees of exposure:

(A) The prevalence of positive tuberculin skin tests (induration ≥ 5 mm) is higher in contacts tested than the prevalence in similar populations residing in the jurisdiction.

(B) A new positive tuberculin skin test is found in a young child.

(C) A documented skin test conversion is found among contacts.

(D) A secondary case of active tuberculosis is found among contacts.

When none of the criteria in this subdivision are met, further expansion of the contact investigation is not necessary.

(7) Contacts with positive tuberculin skin test results, those with symptoms, those with immunosuppressive conditions or those younger than six (6) months of age should have a chest X-ray performed to determine if they have tuberculosis disease. Those with symptoms or with an infiltrate on chest X-ray should submit a sputum sample for AFB smear, culture, and sensitivity.

(8) Contacts with suspected or confirmed active tuberculosis shall be evaluated and managed according to this section.

(9) Contacts identified through contact investigation who have a positive PPD (induration ≥ 5 mm) and a normal chest X-ray, should be offered preventive therapy, usually with isoniazid, regardless of age, unless otherwise medically contraindicated. Contacts should also be considered for treatment of latent infection with tuberculosis in any of the following situations:

(A) Evaluation of other contacts with a similar degree of exposure demonstrates a high prevalence of infection.

(B) The contact is a child or an adolescent, or the contact is immunosuppressed.

(10) Infants who are exposed to a person with infectious active tuberculosis should be evaluated with a tuberculin skin test and a chest radiograph. If the skin test result is negative and the chest radiograph is normal, the infant should be skin tested again at three (3) to four (4) months of age and at six (6) months of age. The infant should receive preventive therapy even if skin test negative. Preventive therapy may be discontinued if the infant is skin test negative at six (6) months of age, provided at least ten (10) weeks have passed since the infant was last exposed to infectious tuberculosis.

(11) The local health officer shall assure that contacts are appropriately evaluated for tuberculosis infection and that a complete course of preventive therapy is recommended for contacts with evidence of tuberculosis infection, regardless of age, unless medically contraindicated. The local health officer is responsible for recording the results of contact investigation and follow-up according to this rule and reporting the results to the department.

(12) The local health department of the jurisdiction shall actively follow every *tuberculosis* case and suspect where the case or suspect resides until they have completed an adequate course of tuberculosis chemotherapy as described in Treatment of Tuberculosis and Tuberculosis In Adults and Children, published in the American Journal of Respiratory and

Critical Care Medicine, Volume 149, pages 1359 through 1374, 1994, or until the patient is determined not to have *tuberculosis*. The duties of the local health department shall include the following:

- (A) Requesting laboratory studies, such as AFB smear and cultures as needed for case ascertainment and for determining whether isolation is necessary.
- (B) Requesting drug susceptibility testing of all initial tuberculosis isolates as needed.
- (C) Assuring appropriate anti-tuberculosis medications are initiated at the appropriate dose in accordance with this subsection.
- (D) Assuring that the pulmonary tuberculosis patient is isolated until confirmed to be noninfectious according to the following criteria:
 - (i) Three (3) consecutive sputum smears are negative for AFB taken at a minimum twenty-four (24) hours apart.
 - (ii) Clinical improvement is documented.
 - (iii) The patient is known to be on adequate anti-tuberculosis medication.
- (E) Assessing that medication is taken as prescribed. Directly observed therapy is the standard of care for achieving adherence.
- (F) Documenting conversion of sputum and culture to negative for AFB.
- (G) Contact investigation.

Sec. 107. Tularemia. The specific control measures for tularemia (infectious agent: *Francisella tularensis*) are as follows:

- (1) An investigation shall be conducted by the local health officer for case ascertainment and identification of infection source.
- (2) Standard precautions for hospitalized patients are required.
- (3) Quarantine is not required.
- (4) Protection of contacts is not required.

Sec. 108. Typhoid Fever. The specific control measures for typhoid fever (infectious agent: *Salmonella typhi*) are as follows:

- (1) An investigation by the local health officer shall be conducted immediately to determine if the affected individual is a food handler, day care worker, or health care worker. Further investigation shall be performed to determine food consumption history for three (3) weeks prior to the onset of symptoms. Every case should be investigated for an actual or probable source. The investigation shall focus on identifying:
 - (A) unreported cases or carriers;
 - (B) contaminated food, water, milk, shellfish, or other food sources; and
 - (C) recent travel history.

All members of travel groups in which a case has occurred shall be interviewed for probable source of infection and additional cases. When outbreaks are associated with restaurants or other food service operations, all food handlers shall be screened for *Salmonella typhi*. Household members and close contacts of the case shall be excluded from food handling, child care, and health care employment until they have two (2) negative stool and urine cultures taken twenty-four (24) hours apart.

(2) Contact precautions for diapered or incontinent patients less than six (6) years of age for the duration of the illness, and standard precautions for other hospitalized patients. For others, the following guidelines shall apply:

(A) Infected persons, whether clinically ill or not, shall be excluded from employment involving food handling, or direct care of children or hospitalized or institutionalized patients. Infected children shall be excluded from day care centers and schools until three (3) consecutive fecal and urine specimens taken at intervals of not less than twenty-four (24) hours, and not earlier than one (1) month after onset, and not earlier than forty-eight (48) hours after the last administration of antibiotics are negative for *Salmonella typhi*. If any one (1) of this series is positive, an infected person whose employment involves food handling shall continue to be excluded until three (3) consecutive fecal and urine specimens are negative for *Salmonella typhi* taken at intervals of not less than twenty-four (24) hours, and not earlier than forty-eight (48) hours after last administration of antibiotics.

(B) Persons whose employment does not involve food handling, but whose employment required their exclusion from work under this section, and who are still infected after the initial follow-up testing, may be returned to work provided that all of the following have been met:

(i) They have been fully compliant with all instructions and screening requirements under this section.

(ii) The local health officer or his or her designee discusses with the asymptomatic worker his or her symptoms and determines that he or she is indeed asymptomatic, and that the worker is further counseled about measures, such as hand washing, that shall be followed to prevent transmission of disease.

(iii) The local health officer or his or her designee contacts the employer to reemphasize the need to comply with local and state rules requiring proper hand washing facilities for all employees, and to correct any observed lapses in hygienic measures of any employees.

(iv) Household and other intimate contacts of the patient shall be excluded from employment involving food handling, or direct care of children or hospitalized or institutionalized patients until two (2) fecal and urine cultures, taken at least twenty-four (24) hours apart, are determined to be negative for *Salmonella typhi*.

(3) Concurrent disinfection is required. Fecal material, urine, and articles soiled with either require disinfection. Fecal matter and urine may be disposed of directly in a sanitary sewer system. Terminal cleaning is required.

(4) Immunization is available for those who may be exposed to carriers. Immunization is of little value to family, household, or other contacts exposed to active cases.

Sec. 109. Endemic Typhus. The specific control measures for endemic typhus are as follows:

- (1) An environmental investigation for the presence of rodents or squirrels, or both, around the premises or the home of the patient shall be done. Provide guidance on the use of insecticides to kill rodent fleas as well as rodent exclusion from the premises or home.
- (2) Standard precautions are required for hospitalized individuals.

Sec. 110. Chickenpox. The specific control measures for chicken pox are as follows:

- (1) An investigation of primary varicella disease resulting in hospitalization or death shall be performed by a department-trained immunization field representative to ascertain immunization history, history of underlying chronic or immunosuppressive disease, and resultant complications.
- (2) For hospitalized patients, institute airborne and contact precautions.
- (3) Concurrent disinfection of articles soiled by nose or throat discharges.
- (4) Susceptible children with known recent exposure to chicken pox who must remain in a hospital setting for medical reasons may be quarantined for a period from ten (10) to twenty-one (21) days after exposure (up to twenty-eight (28) days if Varicella-Zoster Immune Globulin (VZIG) had been given). Infected persons shall be excluded from schools and day care centers, public gatherings, and contact with susceptible persons outside the household until vesicles become dry.
- (5) VZIG may be given within ninety-six (96) hours of exposure to prevent or modify disease in certain close contacts of cases. VZIG is available from regional offices of the American Red Cross, or through a central ordering number (800) 272-7972 for certain high-risk individuals significantly exposed to chicken pox. VZIG should be utilized in newborns of mothers who develop chicken pox within five (5) days before or within forty-eight (48) hours after delivery. Other susceptible high-risk individuals who should be considered for VZIG include the following:
 - (A) Immunocompromised susceptible children and adults.
 - (B) Hospitalized premature infants (twenty-eight (28) weeks gestation or more) whose mothers lack a prior history of chicken pox.
 - (C) Premature infants of less than twenty-eight (28) weeks gestation, or weighing one thousand (1,000) grams or less (regardless of maternal history).
 - (D) Susceptible pregnant women.

Sec. 111. Yellow Fever. The specific control measures for yellow fever are as follows:

- (1) An investigation shall be performed by a department-trained immunization field representative in cooperation with the local health officer. The investigation shall include laboratory confirmation, immunization status, and history of foreign travel in three (3) to six (6) days prior to onset. Identify traveling companions who may also have been exposed.
- (2) Standard precautions are required for hospitalized individuals.

Sec. 112. Yersiniosis. The specific control measure for Yersiniosis (infectious agents: *Yersinia enterocolitica* or *Yersiniosis pseudotuberculosis*) are as follows:

- (1) An investigation by the local health officer shall be conducted within seventy-two (72)

hours to determine if the affected individual is a food handler, day care attendant, or health care worker. The investigation shall include food consumption history, exposure to contaminated water, and exposure to animals three (3) to seven (7) days prior to onset. Interview meal companions for additional cases and if a commercial food product or restaurant is suspected, conduct active surveillance for additional cases.

(2) Contact precautions are required for diapered or incontinent children less than six (6) years of age. Standard precautions are required for other hospitalized patients.

(3) Symptomatic persons shall be excluded from the following:

(A) Employment involving food handling.

(B) Direct care of children.

(C) Hospitalized or institutionalized patients.

(4) Asymptomatic excluded workers may return to work provided there is no indication of poor personal hygiene and the worker understands the importance of good hand washing procedures.

References

Sec. 113. (a) The following documents are hereby incorporated by reference:

(1) Centers for Disease Control and Prevention publication: Case Definitions for Infectious Conditions Under Public Health Surveillance, MMWR, Recommendations and Reports, Volume 46, No. RR-10, May 2, 1997.

(2) Centers for Disease Control and Prevention publication: 1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, MMWR, Recommendations and Reports, Volume 41, No. RR-17, December 18, 1992.

(3) Guideline for Isolation Precautions in Hospitals, Infection Control and Hospital Epidemiology, Volume 17, No. 1, January 1996. Copies may be obtained from Infection Control and Epidemiology, 6500 Grove Road, Thorofare, NJ 08086.

(4) Centers for Disease Control and Prevention: 1994 Revised Classification System for Human Immunodeficiency Virus Infection in Children Less Than 13 Years of Age MMWR, Volume 43, No. RR-12, September 30, 1994

(5) Control of Communicable Diseases Manual, 17th Edition, 2000, a publication of the American Public Health Association, Washington, D.C. Copies may be obtained from American Public Health Association, 800 I Street NW, Washington, D.C. 20001-3170.

(6) Centers for Disease Control and Prevention publication: Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials, November 1997.

(7) Centers for Disease Control and Prevention: CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, Volume 48, No. RR-13, December 10, 1999.

(8) Centers for Disease Control and Prevention: MMWR 1998 Guidelines for Treatment of Sexually Transmitted Diseases, January 23, 1998, Volume 47/RR1

(9) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, as published by Centers for Disease Control and Prevention in Morbidity and

Mortality Weekly Report, October 28, 1994, Volume 43, No. RR-13

(10) Treatment of Tuberculosis and Tuberculosis In Adults and Children, published in the American Journal of Respiratory and Critical Care Medicine, Volume 149, pages 1359 through 1374 (1994). Copies may be obtained from the American Thoracic Society, 1740 Broadway, New York, New York 10019-4374.

(b) All incorporated material is available for public review at the department.

(c) Copies of MMWR publications may be obtained from Centers for Disease Control and Prevention, MMWR Series, Mail Stop C-08, 1600 Clifton Road, N.E., Atlanta, Georgia 30333.